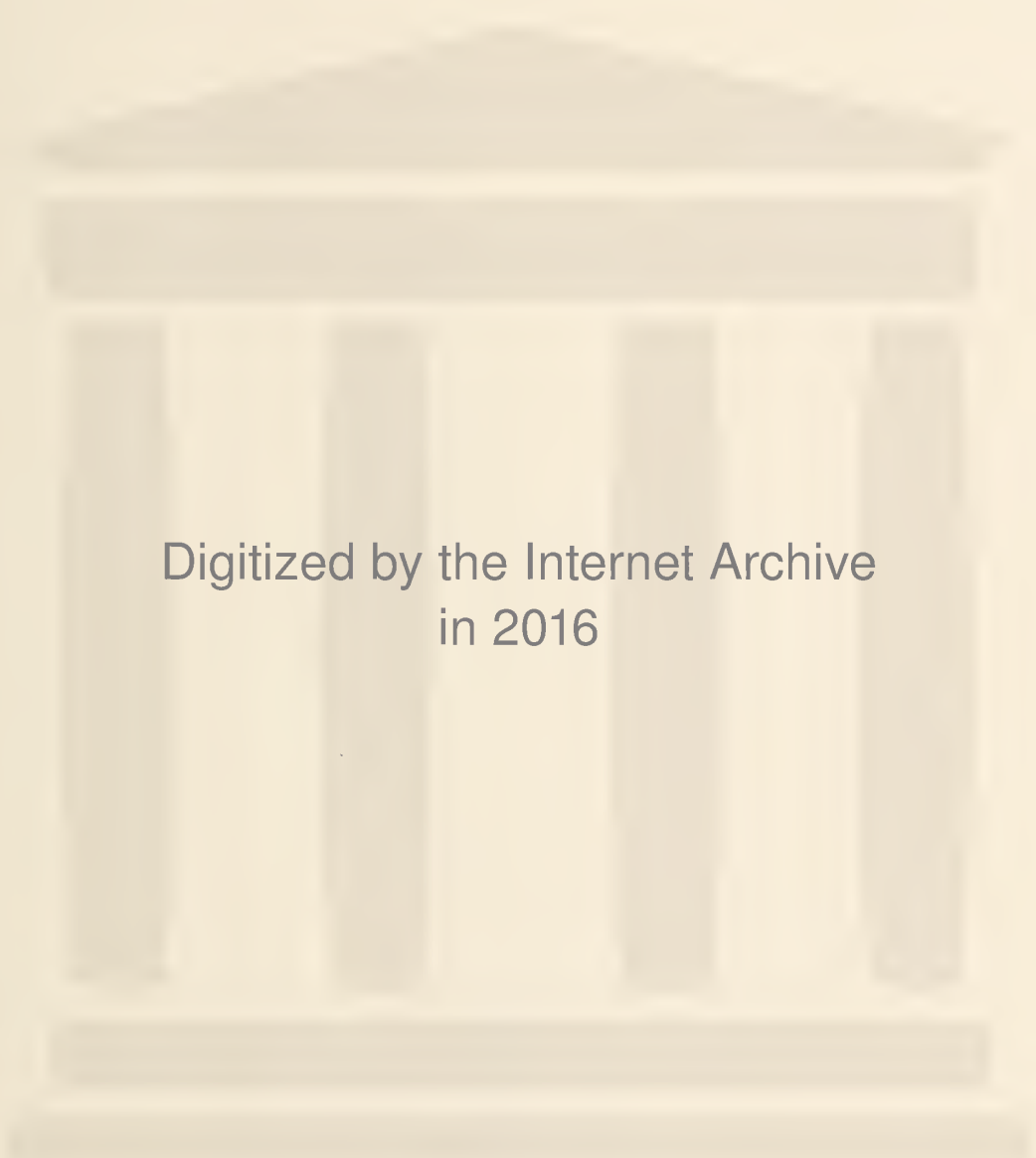


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OKLAHOMA STATE MEDICAL ASSOCIATION
JULY 1987



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HYDROCODONE		X			X
CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975, 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.

WARNINGS:

Drug Abuse and Dependence: VICODIN® is subject to the Federal Controlled Substances Act (Schedule II). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.

Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS:

Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.

Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.

Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.

Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.

Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression: (See WARNINGS.)

DOSEAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.

The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982.

5685

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.

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OKLAHOMA STATE MEDICAL ASSOCIATION

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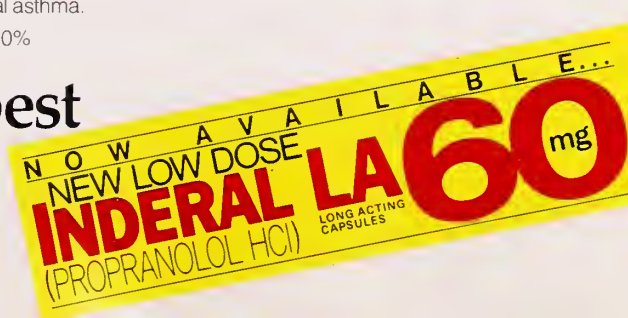
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Please see next page for brief summary of prescribing information.



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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE CIRCULAR)

INDERAL® LA brand of propranolol hydrochloride (Long Acting Capsules)

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension. It may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first-degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3 , and decreasing T_3 .

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should

be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to return of increased intraocular pressure.

CLINICAL LABORATORY TESTS. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions especially in patients with severe cardiomyopathy, congestive heart failure or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenyltolerone, phenobarbital, and rilampin accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and lidocaine have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS. INDERAL is excreted in human milk. Caution should be exercised when INDERAL (propranolol HCl) is administered to a nursing woman.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. Bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of Raynaud type.

Central Nervous System. Light-headedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy, visual disturbances, hallucinations, vivid dreams, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slight clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy and vivid dreams appear dose related.

Gastrointestinal. Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic. Pharyngitis and agranulocytosis/erythematous rash, fever combined with angina and severe throat, laryngospasm and respiratory distress.

Respiratory. Bronchospasm.

Hematologic. Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-immune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. Alopecia, LE-like reactions, psoriasisiform rashes, dry eyes, male impotence and Peyronie's disease have been reported rarely. Oculocutaneous reactions involve the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION — Dosage must be individualized. The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 160 mg may be required. The time needed for full hypertensive response to a given dosage may vary and may range from a few days to several weeks.

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If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (WARNINGS).

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1. INDERAL LA National Compliance Evaluation Program. Data on file, Ayerst Laboratories.
2. Ravid M, Lang R, Jutrin I. The relative antihypertensive potency of propranolol, oxprenolol, and metoprolol given once daily. *Arch Intern Med* 1985; 145:1321-1323.

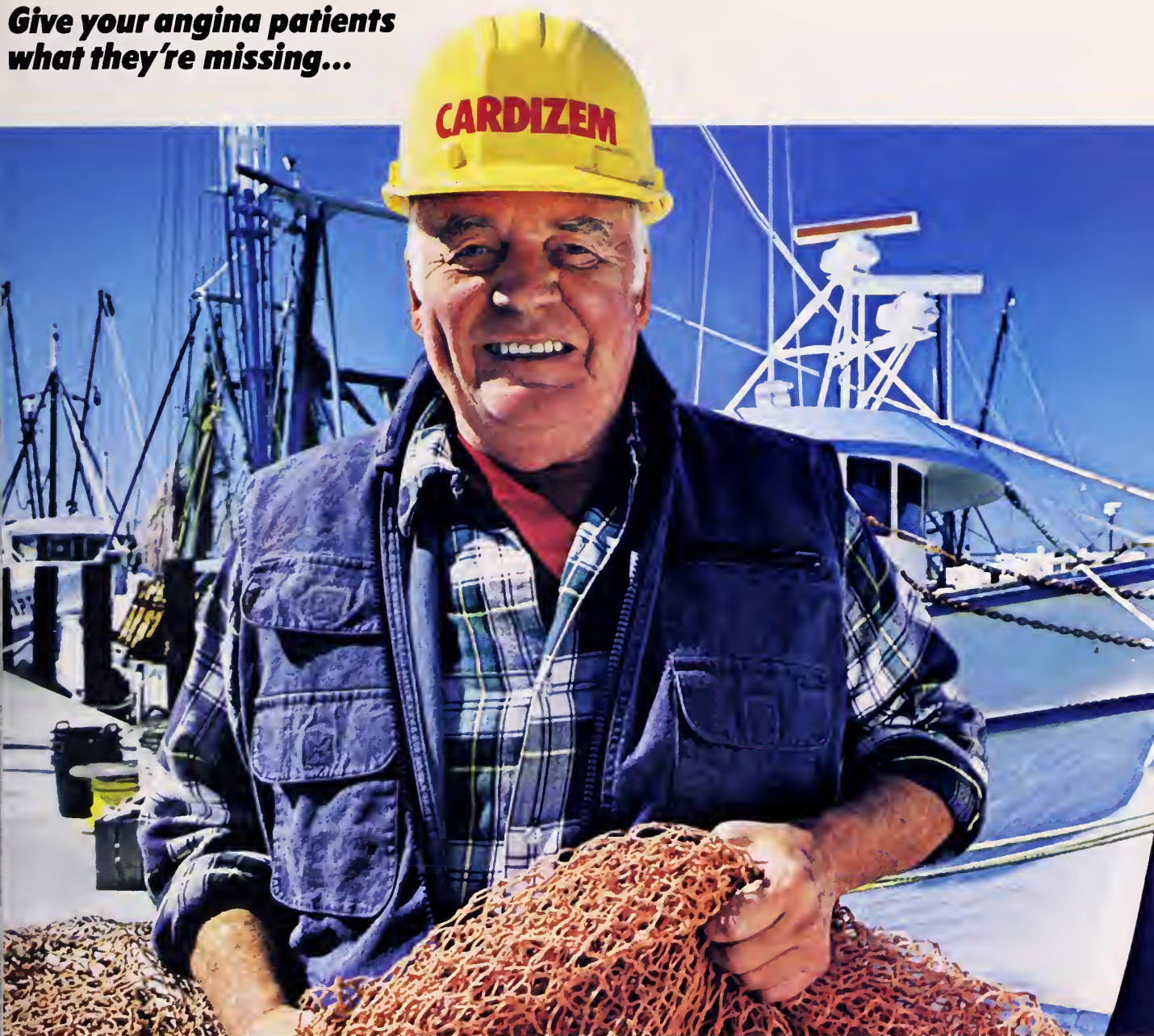
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Brief Summary

Professional Use Information

CARDIZEM[®]

(diltiazem HCl) 30 mg and 60 mg Tablets

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.

2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).

Experience with the use of CARDIZEM

alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.

3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.

4. **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic

function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes, however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in *in vitro* bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy, Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably asso-

ciated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

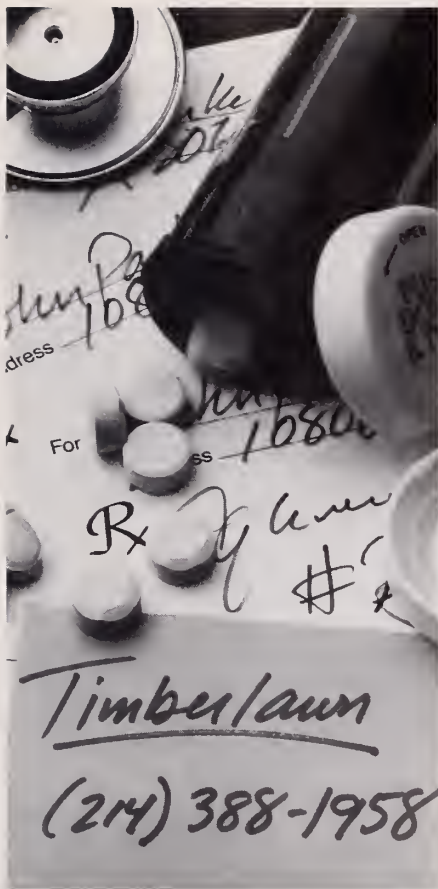
Cardiovascular	Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.
Nervous System	Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.
Gastrointestinal	Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.
Dermatologic	Petechiae, pruritus, photosensitivity, urticaria.
Other	Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarthralgia, pain, polyuria, sexual difficulties.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. Issued 7/86 See complete Professional Use Information before prescribing.

References: 1. Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers. Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. *Am Heart J* 1983; 106(6): 1341-1347. 2. Shapiro W: Calcium channel blockers. Actions on the heart and uses in ischemic heart disease. *Consultant* 1984; 24(Dec): 150-159. 3. Johnston DL, Lesoway R, Hurm DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris. A placebo-controlled, double-blind, randomized, crossover study. *Am J Cardiol* 1985; 55: 680-687. 4. Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): *Heart Disease: A Textbook of Cardiovascular Medicine* ed 2. Philadelphia, WB Saunders Co, 1984; chap 39. 5. Schroeder JS: Calcium and beta blockers in ischemic heart disease. When to use which. *Mod Med* 1982; 50(Sept): 94-116.

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Transformed Competency

I am mystified, to say the least, by the position assumed by third-party (partial) payers relative to their beneficiaries' competency to judge the quality and appropriateness of the care they receive from physicians.

Initial determinations of quality are, with rare exceptions, based wholly and exclusively on those entries which appear or do not appear in the medical record. In a real sense, the determinations are in fact not of the quality of care rendered but of the quality of the medical record.

The individuals charged with the task of determining the quality of care do not talk to patients or even consider the results of the care the patients received.

The reviewers are paperwork detectives, and their aloof refusal to talk to patients and families is justified by an unpublicized conviction that patients are incompetent and unable to judge the quality of the medical care they receive. Even if they had the time and money necessary to conduct such surveys, they say, the results would be meaningless because patients have no ability to distinguish good medical care from bad medical care. It follows that the reviewers steadfastly insist that if it isn't documented in the record it didn't happen; ergo, if it is documented (written) in the record, it did happen. Unable to write in their records, patients are thus disenfranchised of all their rights to determine the quality of their medical care.

Strange as it may seem, however, such disenfranchisement obtains *only* if the patients do not allege

(in writing, of course) that the quality of their care was poor.

Miraculously, the *complaining* patients are transformed into experts. Their ability and competency to determine the quality of the medical care they received becomes sovereign and virtually incontestable. Their allegations trigger a flood of interviews, investigations, and media releases. Physicians cited in such allegations face certain harassment and increased vulnerability to malpractice litigation. Possible fines, practice restrictions, disciplinary modifications of licensure, and even revocation of licenses face the physicians unfortunate enough to be found guilty of the alleged neglect.

Presumably the determination of guilt will be established by the same or similar "peers" who so piously eschew the merits of listening to what noncomplaining patients have to say about the quality of their care.

The noncomplaining patients continue to be viewed as incompetent. Should they respond to the solicitations to file complaints about the quality of their care which, in their opinion, was poor or substandard, they are transformed. They are competent. They are important. The results of their care are of quintessential interest to a small army of probers who previously insisted they could determine the quality of care from the evidence in the medical record; they had no need to talk to patients or even consider results.

Mystifying.

—MRJ

Serving Two Masters

Traditionally physicians have always had a one-to-one relationship with their patients. This was a contract entered into voluntarily — sometimes written, but most usually a tacit agreement of mutual understanding.

Over the past few years, third parties have been selling health insurance in which the patient agrees (on behalf of the doctor) to be precertified for hospital admission and in some cases for outpatient procedures. The physician signs nothing (unless he is participating in a contract with a third party). In my opinion, this represents a form of involuntary servitude.

There are no objective studies showing unequivocally that this procedure (pre-admission certification) results in any savings to anyone, certainly not the patient (perhaps cost shifting, but that is not a savings to anyone).

Now, there is nothing wrong in intercession on behalf of the patient, but this requirement places the physician in the position of negotiating more for himself than for the patient, with the constant threat that he will not get paid or the hospital will not get paid if he does not cooperate.

By dealing with third parties, many of us have made ourselves so dependent on them that we have a fear that if we do not deal with them, we will not survive.

Isn't it time we quit negotiating with third parties and reaffirmed our doctor-patient relationship?



Isn't it time we said to our patient, "My contract is with you — I will deal only with you — I will furnish all the information you need to deal with your insurance company or third party. I cannot serve two masters — you and your insurance company. Therefore I choose to care for you. I am responsible to you and you are responsible to me."

What do you suppose would happen if the physicians of Oklahoma adopted this policy? What do you suppose would happen if just 70% adopted this policy?

Do you think the third parties would dare withhold payment for a bona fide and justified admission or procedure? I think not. The hue and cry would be heard, loud and clear.

It is time for us to again become the masters of our own destinies. We cannot serve two masters. Let us serve our patient.

If we adopt these policies now, remember:

We are not striking.

We are not withholding care.

We are simply going to reaffirm the Hippocratic oath and allow no one to come between us and our patients.

With unity we can and will reaffirm control over our own destinies.

A handwritten signature in dark ink that reads "M. Joe Crosthwait, MD". The signature is written in a cursive, flowing style.

M. Joe Crosthwait, MD

Outpatient Multidisciplinary Geriatric Assessment II

(Second of two parts)

JAMES W. MOLD, MD; JEFFREY R. STEINBAUER, MD; SHIRLEY C. WUNDER, RN; BEVERLEY SMALL, RN

A comprehensive report, on geriatric assessment and the functions of the Geriatric Multidisciplinary Evaluation Clinic (GMEC) at Oklahoma City's O'Donoghue Rehabilitation Institute, continues . . .

Summary of the First Sixty-Eight Cases in GMEC

Table 1 shows some of the demographic characteristics of the first 68 GMEC patients. Several patients were less than 65 years old, but were felt to be good candidates for team evaluation because of their multiple complex problems.

Referral sources are shown in Table 2. Although 19% of patients were physician-referred, many of these were referred by physicians associated with the Department of Family Medicine who were familiar with the clinic and its staff.

Tables 3 and 4 show data taken from the final problem lists of the 68 patients.

Information obtained by postcard from primary physicians is shown in Table 5. This includes a number of physicians to whom patients having no primary physician were referred. It also includes

some physicians toward whom the patients had some ambivalent feelings. (In these cases, every effort is made by GMEC staff to encourage patients to return to their physician and discuss their concerns with him/her). Many of the patients were very reluctant to see any physician and had not been to a medical clinic prior to GMEC in many years.

Case Examples

The following two cases are representative of the types of patients seen in the GME Clinic. They are neither our most successful nor our least successful in terms of recommendations or outcome.

Case 1: Mrs LT was a 77-year-old single woman referred by Adult Protective Services for evaluation. She had had some cognitive dysfunction for a number of years as well as a past history of alcoholism. Her physician felt that she had had some worsening of cognitive function over the past two years despite very limited alcohol intake. She had a poor short-term memory, some confabulation, a tendency to lose things, and some visual and auditory hallucinations which usually occurred at night, but occasionally during the day. Because of her inability to take care of herself properly, she had been placed in a nursing home in Michigan in 1980. Her daughter had brought her to Oklahoma City to live with her in

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1981 and was able to take care of her until February 1985, at which point the emotional and financial burden became too great. Some physical violence began to occur between mother and daughter. At that point, Mrs LT was placed in a room-and-board facility where she did reasonably well until several weeks prior to evaluation, when a concerned nephew placed her in a nursing home because she had complained to him about the care she was getting where she was.

The daughter once again removed her mother from the nursing home and brought her back to live with her. Mrs LT was difficult to care for because of her cognitive impairment and because she insisted on doing things her own way even when unable to do so. Financially, things had improved somewhat since the daughter had been able to resume her work as a beautician in her home. The patient had a history of a long and difficult life including many episodes of trauma secondary to abuse by men, motor vehicle accidents, and alcohol-related falls. However, there was no specific past history of skull fracture or neurosurgical procedure. She had no history of thyroid disease or syphilis, although the medical

The referring physician admitted to feeling a bit overwhelmed.

history was somewhat sketchy. Additionally, she complained of right leg and abdominal pains. The abdominal pain had recently been complicated by anorexia and a history of melanic stools.

Medical evaluation of the patient revealed a significant cognitive deficit (16 out of 30 on Folstein examination). She had markedly decreased internal rotation and pain on movement of the right hip. (X-rays had confirmed severe osteoarthritis of the hip.) Her medications were Maxzide ½ tablet daily, Modane 1 at HS, Mellaril 10 mg bid, and a vitamin and iron medication. She took aspirin to relieve arthritis pain.

Functional assessment revealed a stable gait with the use of a walker and somewhat less so with a cane. She was capable of toilet transfers but was unable to get in and out of her bathtub. The family

Table 1. Demographic Characteristics of Patients

Mean Age	75
Range	41-91
Sex	51 female 17 male
Marital status	22 married 35 widowed 9 divorced 2 single
Living alone	21 (30%)

had no adaptive equipment other than a cane. She was largely homebound because of her poor walking endurance. She was dependent in all household duties. Her daughter handled her finances, but did not have power of attorney.

Following evaluation and staffing, the GMEC team made the following recommendations:

- The patient's chronic dementia was felt to be secondary to ethanol abuse, although Alzheimer's disease, neurosyphilis, B-12 deficiency, folate deficiency, and thyroid disease were possibilities to be considered. A dementia work-up to include SMAC-20, CBC, B-12, folate, RPR, and thyroid function tests was recommended. As there were no lateralizing signs and the patient had a clear history of chronic disease, a CT scan was not recommended initially. It was recommended that the Mellaril be discontinued since by history it exacerbated the patient's hallucinations. A trial of thiamine and possibly ergoloid mesylates (a mild CNS stimulant) 2 mg tid was suggested. A strategy of support for the daughter was implemented, including patient education and support group recommendations. A Non-Technical Medical Care (provider service) referral was suggested because of the potential for elder abuse, and an application was submitted by the social worker.

- It was felt that the osteoarthritis in her hip should be treated with increased activity followed by periods of rest. Regular walking, followed by application of heat to affected joints, was recommended. Home physical therapy was suggested to initiate the home exercise program. The team suggested that the patient continue to use aspirin for relief of her pain. The purchase of a bathtub transfer seat and a hand-held shower nozzle were arranged by the social worker through Vocational Rehabilitation's Independent Living Program. Due to the degree of the patient's disability and her otherwise reasonably good health, the team felt that

she could be a candidate for hip replacement if the pain worsened or more immobility resulted.

● She had numerous abdominal complaints which were long-standing. The black stools had been present only since she had been on the vitamins and iron. She did, however, complain of abdominal swelling and edema, which raised the question of cirrhosis and intermittent ascites. In addition to the above-mentioned tests, more stool guaiac tests were suggested. Careful monitoring of her weight at home was suggested and antacids recommended to evaluate their effect on the abdominal pain. It was felt that if the patient continued to lose weight or if she had documented hematochezia, a proctosigmoidoscopy and GI series would be indicated. Additionally, an ultrasound study was suggested to detect gallstones and ascites. Since she appeared slightly dehydrated (orthostatic drop in BP with associated increase in pulse), it was suggested that the diuretic therapy be discontinued.

● Her nutrition appeared to be poor. In view of her poor oral hygiene, a dental evaluation was suggested. Vitamin supplementation was recommended and follow-up for continued weight loss was suggested as above.

● Adult Protective Services was encouraged to continue their involvement while the recommendations were being implemented because of the potential for abuse.

● The daughter was encouraged to obtain legal power of attorney.

Three months after the GMEC assessment, Mrs LThad not seen her private physician. However, with the help of Adult Protective Services and based upon the recommendations of the team, she was still living with her daughter without experiencing any known abuse. Her appetite and weight had improved

significantly, and she was able to walk easily assisted only by her cane. She had stopped taking her Maxzide without ill effects. Her affect, memory, and ability to communicate had all improved significantly. The daughter was becoming educated about the care of persons with dementia. A provider was found not to be enough relief for the daughter, so arrangements had been made for Mrs LT to attend an adult day care center three days per week. She was also getting group counseling through the mental health center once a week. Vocational Rehabilitation services had not yet supplied the necessary adaptive equipment, but were apparently still planning to do so. The daughter had obtained power of attorney.

Case 2: Mrs BH was an 82-year-old woman referred by her family physician with a multitude of medical and psychosocial problems. The physician, upon referring the patient, admitted to feeling a bit overwhelmed and unsure where to start in the evaluation and treatment of this patient. Much of the tension in the doctor-patient relationship arose from conflict between the patient and her common-

**The majority
of GMEC referrals
originate from
non-physician sources.**

law husband. The patient was physically dependent due to immobility and had some cognitive impairment (21 out of 30 on the Folstein examination). Her husband was stressed by the caretaking requirements which fell to him. Additionally, the patient was sexually demanding of her husband. This caused him to feel inadequate, and he frequently would assail her verbally or physically. The patient accused him of philandering, and the team felt the patient's dependency might in part be meeting her need of keeping her husband at home. As a result, the husband was considering either nursing home placement or separation/divorce.

The patient had two major functional problems: urinary and fecal incontinence. The urinary incontinence was particularly distressing at night. Evaluation suggested that the urinary incontinence

Table 2. Source of Referral to Clinic

Social agencies (Adult Protective Services, Eldercare, Daily Living Center, etc)	20 (29%)
Family/friend	18 (26%)
Physician	13 (19%)
Self	3 (4%)
Nurse	2 (3%)
No information	12 (18%)*

*During the first few months of operation, the referral source was not consistently documented.

Table 3. Health Related Problems Identified by the Team

Average number of problems identified	10
Range	2-17
Total number of biomedical problems identified	466
Average/patient	7
Total number of functional disabilities identified	152*
Average/patient	2
Total number of social service problems identified	101*
Average/patient	1

*May be a significant underestimate since many problems identified in this category were related to a specific biomedical problem and were therefore not listed separately on the prioritized problem list (eg, gait disturbance — Parkinson's disease, care giver burnout — dementia, etc).

was due to sphincter incompetence and/or detrusor instability. The fecal incontinence only occurred when the patient had loose stools. Both problems were aggravated by her immobility. They also were a significant problem for her husband, who had ostensibly stopped sleeping with the patient as a result.

The patient had a history of polypharmacy. She had a paper bag full of over-the-counter and prescription drugs. She took the drugs sporadically. Her regular medications were chlorthalidone for hypertension and insulin for diabetes mellitus. Her husband made sure she took the insulin regularly.

Her immobility was due to weakness of her leg muscles from disuse. She also had a 20° contracture of her right knee. She was largely dependent on a wheelchair for mobility, although she did occasionally "scoot" on the floor. Her mobility problems seemed to be out of proportion to clinically detectable neurologic or orthopedic disease. She also had some peripheral neuropathy, thought to be secondary to diabetes, and osteoarthritis, which primarily involved the upper extremities. She had a history compatible with coronary artery disease and possibly cerebrovascular disease.

After evaluation by the GMEC team, the following recommendations were made:

- Consideration of a dementia work-up to include a CT scan. The CT scan was indicated because of her bladder problems and her immobility, to evaluate the presence of normal pressure hydrocephalus.

- Physical therapy was suggested to increase range of motion of the knee, improve strength, and possibly help with ambulation.

- Imipramine 25 mg at bedtime, with increased dosage if necessary, was suggested for management of her urinary incontinence. It was felt that this

might also have a salutary effect on her fecal incontinence because of its constipating effect. Kegel exercises and estrogen cream were also suggested to improve urethral sphincter function.

- Metamucil was also prescribed and the patient was encouraged to develop a regular bowel routine.

- She was advised to discard all of her outdated medications, since polypharmacy could exacerbate many of her problems.

- Her physician was advised to suggest acetaminophen for her arthritis symptoms since it had fewer side effects and probably less abuse potential for her.

- B-12 and folate level determinations were recommended in the evaluation of the peripheral neuropathy, with future consideration of heavy metal detection screen if indicated, although past alcohol abuse and diabetes were felt to be the most probable causes of the neuropathy.

- The GMEC team suggested that the diuretic be discontinued or its dosage be reduced because of her incontinence and because of the drug's potassium- and magnesium-wasting characteristics. Indapamide or clonidine were suggested as alternate therapeutic choices for her hypertension.

- A trial of an oral hypoglycemic agent was suggested to evaluate the prospect of discontinuing insulin therapy.

- One tablet of aspirin a day was suggested. If she were to have TIA-like episodes, monitoring of heart rhythm and/or evaluation of the carotid system were felt to be indicated.

Her physician implemented several of these suggestions. He noted that her sensorium improved after she omitted some of her previous prn medications. Urinary and fecal incontinence resolved on a combination of imipramine, estrogen cream, and Kegel exercises. Clonidine and hydrochlorothiazide were prescribed for her hypertension and insulin therapy of her diabetes was continued. She was noncompliant intermittently, and her condition worsened when she did not follow her prescribed medication regimens. She was able to maintain improvement, however, for a year following her visit to the GMEC clinic. At that point, her condition deteriorated somewhat, and she was ultimately admitted to a nursing home.

Her physician mentioned that he felt much more comfortable in managing this patient after the GMEC evaluation. The evaluation helped him organize his approach to treating the patient. The

Table 4. Frequencies of Specific Diagnoses

Number of times diagnosis was made in all 68 patients (percent of patients with the diagnosis)

Cognitive dysfunction (including dementia)	35 (51%)
Disorders of gait and mobility (including falls)	31 (46%)
Significant visual impairment	29 (43%)
Hypertension	22 (32%)
Chronic pain	22 (32%)
Heart Disease (including CAD, CHF, VHD)	21 (31%)
Dental problems	19 (28%)
Depression	18 (26%)
Calcium deficiency (inadequate intake/ excess losses)	16 (24%)
Incontinence (bowel or bladder)	15 (22%)
Arthritis (all types)	11 (16%)
Significant hearing impairment	11 (16%)
Chronic constipation (including laxative dependence)	11 (16%)
Peripheral edema (excluding CHF)	10 (15%)
Dependent for activities of daily living	9 (13%)
Diabetes mellitus	9 (13%)
Sleep disorder	7 (10%)
Social isolation	7 (10%)
Chronic obstructive lung disease	6 (9%)
Cerebrovascular disease (S/P, CVA, TIAs)	5 (7%)

comprehensive nature of the evaluation made him feel more confident that he "wasn't missing anything." He also noticed that alleviating the patient's incontinence markedly improved the situation at home and reduced the husband's anxiety. Although the patient remained inactive and no physical therapy was obtained, the physician felt that the patient and her husband were doing much better as a result of implementation of the other suggestions.

Summary and Discussion

Over 11% of the US population is now over the age of sixty-five years. Oklahoma has a slightly higher percentage (12.4%) of older people than the United States as a whole. The actual and relative numbers of older people are increasing, and this trend is expected to continue well into the next century. The most rapidly growing segment of the population is the group of people over the age of 85 years. Many of these people are frail and have multiple disabilities. It is extremely important that our health care system develop more satisfactory ways to address the needs of this important group of people.

Clearly, most elderly patients can be cared for very adequately by a family physician or internist, particularly if that physician has had some training and/or experience in geriatrics. However, there are significant numbers of frail elderly patients who can benefit from multidisciplinary evaluations by a team

of health care professionals with expertise in geriatric medicine. Once a comprehensive assessment is complete, recommendations can be made that will allow primary care physicians to continue to direct the more effective management of these patients.

Patients, families, and social agencies are somewhat ahead of physicians in recognizing the value of comprehensive geriatric assessment. As has been the experience of other such clinics, the majority of GMEC referrals originate from these non-physician sources. However, we predict that through increased training in geriatrics in graduate and postgraduate training programs, as well as more experience with patients who have undergone comprehensive evaluations, physicians will begin to refer patients with particularly complicated problems to a physician member of the geriatric team for consultation, much as they would refer difficult cardiac patients to a cardiologist.

In designing the GMEC, conscious effort was made to avoid interfering with the patient's relationship with his/her primary physician. Recognizing that the primary physician is in the best position to evaluate the feasibility of the recommendations, an attempt is made to get each patient back to his/her physician quickly for discussion and implementation of the suggestions made by the team. It may be that in some situations, the primary care physician would prefer that the clinic implement the suggestions and return the patient only after treatment is initiated and stabilization is achieved. Communication with primary care physicians regarding their needs and preferences is obviously important and is most easily accomplished when the patient is referred by the physician.

Our experience indicates that most physicians find the GMEC consultation helpful in their management of these patients with complex and difficult problems. Unfortunately, we have fewer data supporting improved outcomes as a result of the

Table 5. Feedback from Primary Physicians
(From postcards mailed out 2 weeks after GMEC assessment)

Total number of cards returned	61 (90%)
Patient seen by MD since GMEC	54 (89%)
GMEC report helpful to MD	58 (95%)
MD willing to refer other patients to GMEC	59 (97%)
MD willing to accept referrals from GMEC	52 (85%)

process. As illustrated by the two case examples, physicians seem to be more likely to respond to biomedical needs and less likely to implement functional or psychosocial interventions. On the

**The primary physician
is in
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the recommendations.**

other hand, families and community agencies such as Adult Protective Services tend to respond to functional and psychosocial needs, neglecting the biomedical ones. In most cases, sending copies of the problem list and recommendations to both the physician and either the patient, a responsible family member, or the referring community agency (with signed consent of the patient or responsible party) has worked well.

The team evaluation strategy used in GMEC can be applied to many settings in which geriatric patients receive health care. These include acute care hospitals (special geriatric inpatient units or

geriatric consultations), day hospitals, rehabilitation hospitals, nursing homes, home health care (where the physician becomes an active member of the home health care agency team), and geriatric life care centers. The process is expensive and time consuming and requires a willingness of various health professionals to work together. However, the benefits to the patient, family, and health care system can be substantial, and the ultimate cost savings to the system easily justifies the initial effort and expense.

□

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Coming in August . . .

Among the manuscripts being considered for publication in August are a review of the findings of a Tulsa breast screening clinic and a report on *Legionella pneumophila* infections in Oklahoma.

Policy Options for Oklahoma Physician Training Programs to Meet Manpower Needs Beyond 2000

F. DANIEL DUFFY, MD; C. S. LEWIS, JR., MD; DEBORAH A. MILLER, MS

Deciding how many physicians in each specialty are required to meet the health needs of future generations of Oklahomans is an important task shared by our state medical schools, residency programs, teaching hospitals, and State Regents for Higher Education. The policymakers in Oklahoma have dutifully tackled the problem by collecting and analyzing manpower data and growth trends for nearly twenty years.¹⁻⁶ Important changes in the supply and needs for physicians have made this a challenging task. A dramatic increase in physicians entering practice in the late 1970s and early 1980s resulted from an expansion of class size of US medical schools, an encouragement of immigration of foreign physicians, and the growth of offshore and other foreign medical schools training US citizens. The Graduate Medical Education National Advisory Committee (GMENAC) Report⁷ first drew attention to the potential oversupply of 70,000 physicians in the US by 1990 and an oversupply of more than 240,000 by 2000. Responding to the national physician manpower supply, the Oklahoma State Medical Association (OSMA) urged the State Regents for Higher Education to study the supply of and needs for physicians in Oklahoma and to recommend appropriate corrections in the current

medical education programs in the state. The regents appointed an Advisory Committee on Physician Manpower and Medical Education, which reported its findings and recommendations in April of 1986.⁸

The recommendations made at that time were:

1. The Oklahoma State Regents for Higher Education and other interested groups should continue to monitor physician manpower and correct for changes in health care delivery systems such as the increased number of persons participating in HMOs.
2. Adjust the 1988 entering class at the University of Oklahoma College of Medicine (OUCOM) and at the Oklahoma College of Osteopathic Medicine and Surgery (OCOMS) to a number of students that is 8% lower than the 1984 entering class. This would be a reduction from 176 to 162 for the University of Oklahoma College of Medicine incoming class and from 84 to 77 for the Oklahoma College of Osteopathic Medicine and Surgery incoming class.
3. To reduce the first-year residency and intern positions available by 7% in 1992 relative to the 1984 number of first-year resident and intern positions.

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TABLE 1.

1986 OKLAHOMA PHYSICIAN SUPPLY AND NEED BY HOSPITAL TRADE AREAS

PRINCIPAL HOSPITAL TRADE COMMUNITY	COUNTIES	SERVICE AREA POPULATION	PRIMARY CARE SUPPLY	CARE NEED	SECONDARY CARE SUPPLY	CARE NEED	TERTIARY CARE SUPPLY	CARE NEED
Okla. City	Oklahoma, Canadian, Blaine, Logan	740100	670	614	775	592	179	268
Enid	Garfield, Alfalfa, Grant, Kingfisher, Major, Woods	115100	92	96	58	92	7	5
Lawton	Comanche, Cotton, Kiowa	145000	72	120	50	116	8	6
Norman	Cleveland, McClain	181600	94	151	97	145	3	8
Ardmore	Carter, Garvin, Jefferson, Johnston, Love, Murray	114200	76	95	31	91	7	5
Ponca City	Kay	51300	36	43	26	41	0	2
Shawnee	Pottawatomie, Hughes, Lincoln, Okfuskee, Seminole	146800	68	122	33	117	1	6
Stillwater	Payne, Noble	77900	50	65	29	62	0	3
Ada	Pontotoc, Atoka, Coal	52500	36	44	24	42	0	2
Chickasha	Grady, Caddo	78500	38	65	18	63	2	3
Duncan	Stephens	45800	25	38	15	37	0	2
Elk City	Custer, Beckham, Dewey, Roger Mills, Washita	83400	47	69	16	67	1	5
Altus	Jackson, Greer, Harmon, Tillman	56600	33	47	15	45	0	2
Durant	Bryan, Marshall	42300	24	35	6	34	0	2
Shattuck	Ellis, Beaver, Harper, Woodward	42400	25	35	9	34	1	2
Guymon	Texas, Cimarron	22800	18	19	1	18	0	1
Muskogee	Muskogee, Adair, Cherokee, Haskell, McIntosh, Sequoyah	181200	116	150	68	145	8	8
Tulsa	Tulsa, Craig, Creek, Delaware, Mayes, Okmulgee, Osage, Pawnee, Rogers, Wagoner	866900	720	720	603	696	136	221
Bartlesville	Washington, Nowata	63100	40	52	49	50	5	3
McAlester	Pittsburg, Latimer, LeFlore	94700	59	79	30	76	3	6
Idabel	McCurtain, Choctaw, Pushmataha	64400	28	53	8	52	0	3
Miami	Ottawa	33800	20	28	9	27	0	1
TOTAL		3300400	2387	2739	1970	2642	361	564

4. Encourage all MD and DO graduates to complete at least three years of postgraduate training before going into practice.
5. Reallocate intern and residency positions by discipline to fit the projected needs in Oklahoma as noted in the GMENAC recommendations for ideal specialty distribution by discipline.
6. Ensure that in-migrating foreign medical graduates are of a caliber equal to US medical graduates.

Because the time from entering medical school to entering practice spans nearly a decade, corrections made to solve today's manpower problems may miss the future target of adequate supply and distribution of the right specialties of physicians. Rapidly changing schemes for financing medical services, changing immigration laws for physicians, and changing interest by young persons in seeking a medical career make projections extraordinarily difficult. Cautious reduction now and continuing reevaluation with mid-course corrections were the thrust of the Regent's April '86 report.

In working with the Regents' Advisory Committee on Physician Manpower and Medical Education, we have continued to collect Oklahoma physician manpower data and analyze the current status and trends so that the data may be useful to the decisionmakers. We present our most recent findings in this report.

Methods

The methods used to estimate the needs for each physician specialty for the state, each hospital trade area, and each county were published in detail previously.⁹ Two commercial spreadsheet programs (Lotus 1-2-3 and SMART) were used for the calculations of the Physician Manpower Estimate Model (PMEM). Revisions in the initial methodology⁹ were made based on criticism of reviewers; changing assumptions about physician manpower productivity, utilization, and education; and the emergence of the HMO physician staffing model.

HMO-Adjusted GMENAC Physician Manpower Needs. The number of physicians Oklahoma needs in each specialty was determined by multiplying the GMENAC-determined number of physicians in a

specialty per 100,000 population by the population of the state, hospital trade area, or county. GMENAC determined that 191 physicians per 100,000 population was an ideal number when most of the medical service was provided in a fee-for-service (FFS) system. However, since the GMENAC study was completed, larger portions of the population have begun receiving care through alternative systems. Recent studies have reported that staff model health maintenance organizations (HMOs) employ 120 physicians per 100,000 population. As more of the

In 1987 Oklahoma remains undersupplied.

population receives medical care from HMOs, the GMENAC-suggested physician requirements will overestimate the actual needs.

We used Tarlov's suggested computation¹⁰ to adjust downward the physician requirements for a population served by both a fee-for-service system (FFS) and an HMO system. For the segment of the population served by HMOs, we assumed that 55% of the 120 physicians would be primary care physicians distributed among family practice, osteopathic general practice, internal medicine, pediatrics, and obstetrics and gynecology in the same proportion as the GMENAC model. For the segment served by the FFS system, 45% of the 191 physicians would provide primary care. For the secondary and tertiary care physician specialties, the population served by HMOs would need 45% of the 120 physicians, and the population served by FFS would need 55% of 191 physicians.

In the HMO segment, the number of physicians in each specialty was determined by multiplying the total needed for secondary and tertiary care physicians by the GMENAC percentage in that specialty. The total number of physicians needed for each specialty was calculated by adding the number needed for the population receiving care in the FFS segment to the number of physicians needed for the population served in the HMO segment. The adjusted physician needs number resulted in an overall reduction in the number of physicians needed, but there is a greater reduction in the secondary and tertiary care specialties.

TABLE 2

ESTIMATED OKLAHOMA PHYSICIAN MANPOWER SUPPLY AND DEMAND 1987

1	2	3	4	5	6	7	8	9	10	11	12
	1986 MD & DO TOTAL PRACTICE 3233700	EST. 1 YEAR MD GRADS	EST. 1 YEAR DO GRADS	EST. MD GRADS EXIT OKLA	CALC. DO GRADS EXIT OKLA	EST. PHYS. MOVE INTO OKLA	EST. PHYS. LEAVE PRACT. 2.00% PER YR.	1987 EST OKLA PHYS. SUPPLY	1987 NEEDS PHYS. 3283700 8% IN HMO	1987 ESTIMATED OKLAHOMA PHYSICIAN SURPLUS DEFICIT	% OF 1987 EST. PHYS. NEED
PMTC PRIMARY CARE											
FAMILY PRACTICE	885	31	0	-11	0	14	-18	901	811	89	111
OSTEOPATHIC G.P.	455	0	41	0	-18	0	-9	468	301	167	156
INTERNAL MEDICINE	502	19	5	-10	-2	12	-10	516	930	-414	56
PEDIATRICS	270	21	1	-13	0	6	-5	279	400	-121	70
OB GYN	275	7	1	-2	0	8	-6	283	318	-34	89
TOTALS	2387	78	48	-36	-22	40	-48	2448	2761	-313	89
PMTC SECONDARY CARE											
ANESTHESIOLOGY	217	12	2	-3	-1	5	-4	228	272	-44	84
CARDIOLOGY	123	3	0	-2	0	4	-2	126	100	25	125
CHILD PSYCHIATRY	11	1	0	0	0	0	0	12	117	-105	10
DERMATOLOGY	56	3	0	-2	0	2	-1	57	90	-33	64
EMERGENCY MEDICINE	147	6	0	-4	0	4	-3	150	175	-25	86
GENERAL SURGERY	268	6	2	-3	-1	6	-5	272	305	-32	89
HEMATOLOGY ONCOLOGY	43	3	0	-2	0	2	-1	46	117	-71	39
PREVENTIVE MED.	59	0	0	0	0	3	-1	60	95	-34	64
OPHTHALMOLOGY	138	3	1	-2	0	1	-3	139	150	-12	92
ORTHOPEDIC SURG	167	5	1	-3	0	4	-3	170	196	-25	87
OTOLARYNGOLOGY	74	2	1	-1	0	1	-1	76	104	-28	73
PATHOLOGY	122	3	1	-1	0	4	-2	126	175	-49	72
PSYCHIATRY	212	5	0	-2	0	6	-4	216	499	-282	43
RADIOLOGY	238	8	2	-3	-1	3	-5	242	233	9	104
UROLOGY	95	3	1	-1	0	1	-2	97	100	-3	97
SECONDARY TOTALS	1970	63	11	-28	-5	45	-39	2017	2727	-709	74
PMTC TERTIARY CARE											
ALLERGY	23	0	0	0	0	0	0	23	27	-4	86
ENDOCRINOLOGY	16	1	0	0	0	1	0	18	27	-9	67
GASTROENTEROLOGY	46	2	0	-1	0	2	-1	48	84	-36	57
INFECTIOUS DISEASES	10	1	0	-1	0	1	0	11	29	-18	37
NEONATOLOGY	12	1	0	0	0	1	0	13	17	-3	80
NEPHROLOGY	18	1	0	-1	0	1	0	19	36	-17	53
NEUROLOGY	47	2	0	-1	0	1	-1	49	71	-22	68
NEUROSURGERY	38	1	0	0	0	0	-1	38	34	4	111
NUCLEAR MEDICINE	5	1	0	-1	0	0	0	6	52	-46	11
PEDIATRIC ALLERGY	2	0	0	0	0	0	0	2	12	-10	17
PEDIATRIC CARDIOL.	5	0	0	0	0	0	0	5	15	-10	33
PEDIATRIC ENDOCRIN	0	1	0	0	0	0	0	1	10	-9	10
PEDIATRIC HEM. ONC.	3	1	0	0	0	0	0	4	21	-18	17
PEDIATRIC NEPH.	2	0	0	0	0	0	0	2	5	-2	47
PHYSICAL MED. REHAB.	15	0	0	0	0	0	0	15	41	-27	35
PLASTIC SURGERY	35	1	0	-1	0	1	-1	36	35	1	102
PULMONARY	33	3	0	-2	0	2	-1	36	47	-11	76
RHEUMATOLOGY	21	0	0	0	0	1	0	21	22	-1	97
THORACIC SURGERY	30	1	2	-1	-1	0	-1	31	27	5	118
TERTIARY CARE TOTALS	361	16	2	-7	-1	11	-7	376	610	-235	62
OTHER*	82	11	0	0	0	5	-2	85		85	0
PRACTICING PHYSICIANS	4800	168	61	-70	-27	97	-96	4926	6098	-1171	81
LICENSED RESIDENTS	580							580			
LICENSED PHYSICIANS	5380							5506	6098	-591	90
RES. .35 FTE PRACT.*	203							203			
TOTAL FTE PRACTICE	5003							5129	6098	-1171	84
PHYS 100000 POP**	166							168	186	-18	90
FTE PHYS 100000 POP***	155							156	186	-29	84

*Each Resident is estimated to provide 35% of the productivity of a full time practicing physician. **Includes Residents

***Includes adjustment of 35% FTE for each resident.

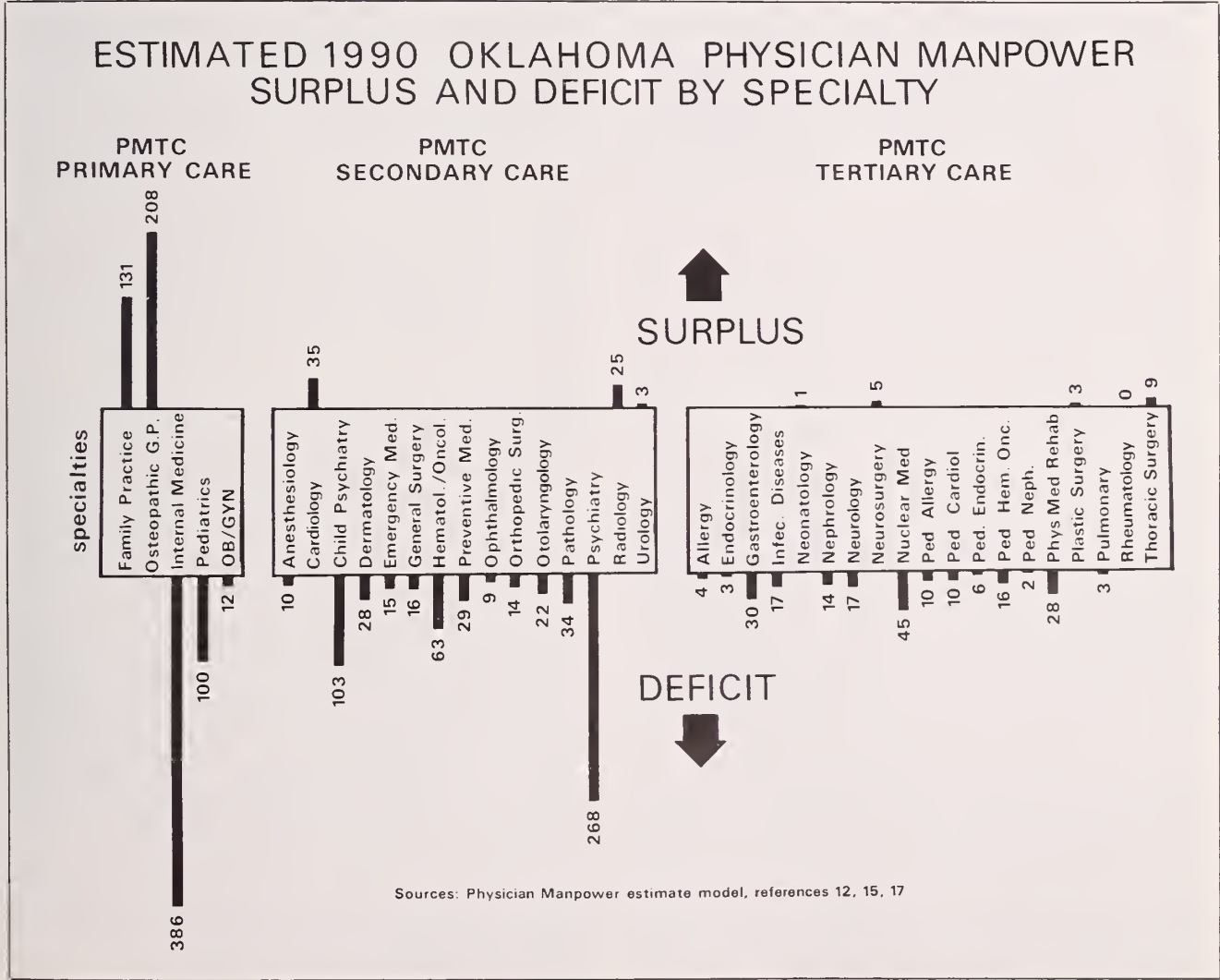
HMO-Adjusted Physician Manpower Needs for Geographic Areas. To determine the requirements for physicians in each county in Oklahoma, we obtained the 1985 population of each county from the Oklahoma Population Estimates, US Department of Commerce, Bureau of the Census (Table 1). The 1986 supply of physicians for each county was represented as a percent of the calculated service-adjusted need for physicians for each county.

Since people require a primary care physician close to home, the number of primary care physicians needed by each county was determined to be the total HMO-adjusted primary care physicians per population need of the county. We assumed that most of the physicians providing secondary care will live and practice near larger hospitals located in counties

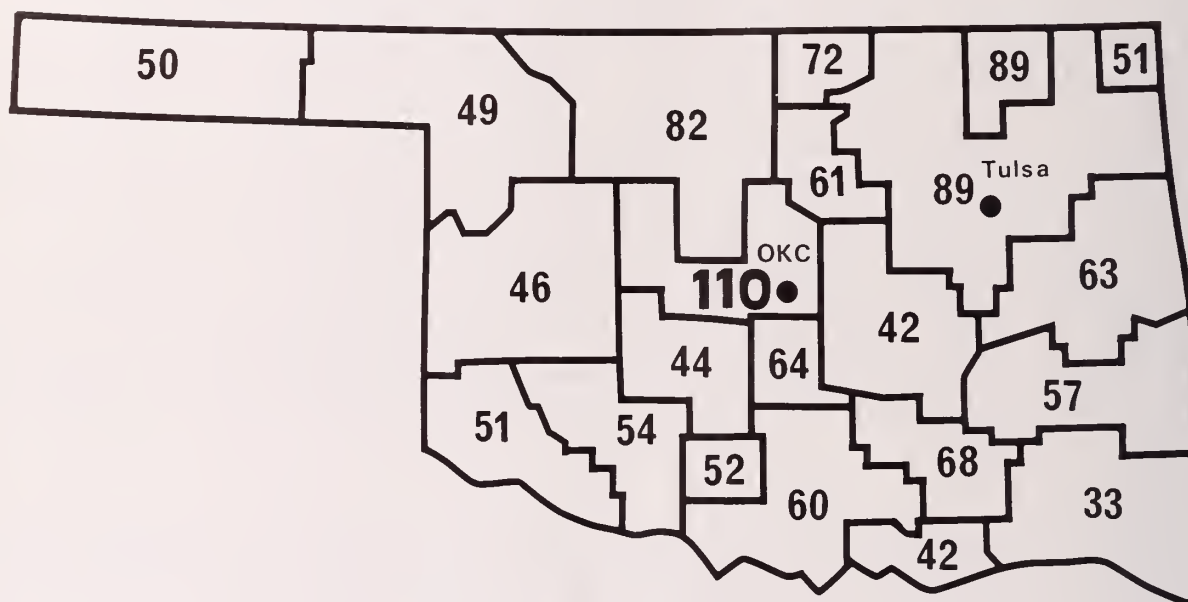
containing centers of commerce. Finally, we assumed that most physicians who provide tertiary care will live in Oklahoma City and Tulsa and practice in hospitals in those cities. This aggregation of physicians in hospitals providing increasingly specialized services and serving increasingly larger geographic areas will create an appropriate, unequal distribution of physicians per population among the counties of Oklahoma. Tulsa County and Oklahoma County will have a physicians per population ratio greater than the GMENAC 191/100,000; other counties will have fewer than 191 physicians per 100,000 population.

The Oklahoma Health Systems Agency has distributed the 77 Oklahoma counties among 22 hospital trade areas representing the travel and

Figure 1.



% PHYSICIAN MANPOWER NEEDS MET IN HOSPITAL TRADE AREAS



Sources: Physician Manpower estimate model, references 12, 15, 17

Figure 2.

hospital utilization patterns of the persons living in the counties comprising the trade area.¹¹ We identified a principal city with a secondary care hospital in each of the trade areas as a regional center.

For the analysis of geographic needs for physicians by specialty, we assigned the *HMO-Adjusted GMENAC Needs* to the population of each of the 77 counties in the following manner (Table 1):

(1) Fifty-five of the counties were identified as Primary Care Counties and each was assigned 100% of its population's primary care needs and 50% of its population's secondary care needs;

(2) Twenty of the counties were identified as Secondary Care Counties and each was assigned 100% of its population's primary care and secondary care needs, 50% of the secondary care needs for the populations of each of the other counties in the trade area, and 25% of the tertiary care needs of all of the counties in the trade area;

(3) Two counties, Tulsa and Oklahoma, were each assigned their own population's primary, secondary, and tertiary care needs; 50% of the secondary care needs for the populations of the other counties in the Tulsa or Oklahoma County hospital trade area; and

75% of the tertiary care needs of the populations of the counties in Eastern Oklahoma assigned to Tulsa County and Western Oklahoma assigned to Oklahoma County.

Population Projections. The population estimates for Oklahoma for 1990, 2000, and 2010 were obtained from the Oklahoma Department of Commerce.¹² Population estimates for each county in 1985 were obtained from Oklahoma Population Estimates, US Department of Commerce, Bureau of the Census.¹³

The Supply of Oklahoma Practicing Physicians in 1986. The physician data base of the Oklahoma State Board of Medical Examiners provided the location and specialty of each licensed physician in practice in Oklahoma as of September 1986. The Directory of Osteopathic Physicians for 1986 provided the location and specialty of the Osteopathic physicians practicing in Oklahoma in 1986.¹⁴

The Graduation of Physicians from Oklahoma Training Programs. For MDs, the number of graduates in 1986 from a final residency or fellowship

program was obtained from the University of Oklahoma Health Sciences Center College of Medicine, Office of the Dean. The number of graduates from osteopathic graduate medical education programs was obtained from the *Status Report on Practice/Residency Locations of Oklahoma College of Osteopathic Medicine and Surgery Graduates 1986*.¹⁵ The graduates from the Oral Roberts College of Medicine in Tulsa are not included in the data since the stated mission of this institution is to provide physicians for the world rather than for Oklahoma.

Out-Migration of Oklahoma Physician Graduates. Each year a number of the graduates of residency and fellowship programs take positions in practice outside of Oklahoma. To estimate the number of graduates who will not enter practice in Oklahoma, we determined the average percentage of graduates of the MD programs from 1982 through 1986 who left Oklahoma for practice elsewhere. The average percentage leaving was then used to estimate the number of graduates who will have left the state from 1986 to the study year.

Calculated Out-Migration of Osteopathic Graduates. Since 1980, fifty-five percent of the graduates of OCOMS practice in Oklahoma; 45% practice out of the state.¹⁵ In the spreadsheet, we assigned 75% of the losses to general practice and 25% to the other specialties.

In-Migration of Physicians. Each year for the past 14 years, Oklahoma has experienced a net gain in MDs over the number produced by the University of Oklahoma College of Medicine. To estimate the number of physicians in each specialty who will move into Oklahoma to practice, we determined the number of MD physicians in each specialty who reported obtaining all of their residency and fellowship training in a state other than Oklahoma for the years 1980 to 1985. We averaged the number of such physicians in each specialty to determine the in-migration rate per year. Although it can be assumed that there will be some in-migration of osteopathic physicians, there are no data available to enable an estimation.

Attrition of Physicians. Attrition in the number of practicing physicians occurs by physicians leaving practice, moving after establishing a practice, retiring, or dying. Although not lost to practice,

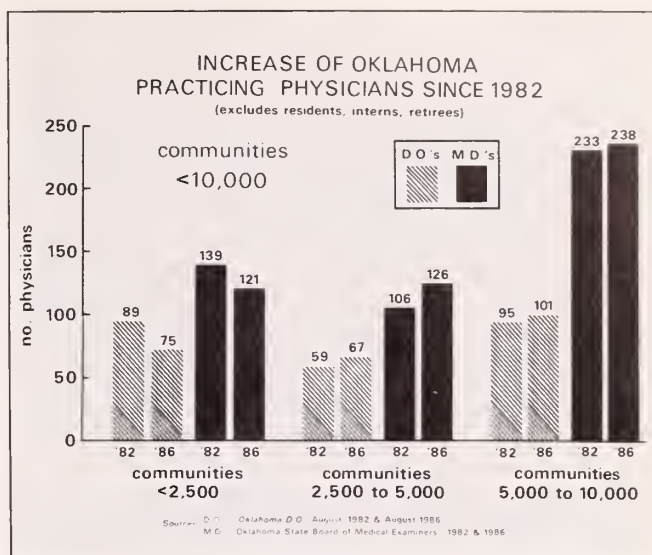


Figure 3.

physicians with a reduced productivity, as might occur, for example, with a female physician working only part time in order to raise a family, can be accounted as an attrition of practicing physicians. In our initial study, we assumed an attrition rate of 1.6% per year. Assuming the average practice life of a physician to be 35 years (65-year retirement minus 30 years at start of practice), one would expect an attrition rate of 2.7%. The lower attrition rate for Oklahoma was based on actual data and the presumed lower mean age of the Oklahoma physician. Since almost 30% of the current medical students are women, we assumed that a reduced productivity will occur as more women enter practice. An attrition rate of 2% was used in this paper. The model allows planners to select any attrition rate and observe its effects.

Supply of Physicians by Specialty for the Study Year. The total number of physicians in each specialty for the study year was calculated as the sum of the physicians practicing in 1986, plus the sum of the yearly production and the sum of in-migrating physicians, minus the sum of the graduates leaving the state and the total physicians lost to practice.

The Surplus/Deficit of Specialty for Study Year. The calculated need for each specialty was then subtracted from the calculated supply of physicians to give the surplus or deficit number of physicians in the specialty.

Adjusted Total Physician Supply. There are a small number of unclassified physicians added to the

total of physicians in practice. Each year there are a number of graduates who will enter unclassified or "other" fields of medicine. Residents, mainly located in Tulsa and Oklahoma counties, provide medical care and are counted in the total physicians for the state as 35% of a full-time practitioner. Adjusting the sum of the physicians in each of the specialties with the "other" or not-classified physicians and 35% of the residents provides the adjusted total physicians per population in the study year.

Assumptions Used in This Study. The population growth rate will be about 1% per year; 15% of the population will be served by HMOs by 1990, 20% by 2000, and 25% by 2010; attrition and reduction in productivity will result in a loss of 2.0% of the physician supply each year; specialists will be produced by OUCOM and OCOMS at one of two reduced rates, 8% and 15%; and in-migration of MDs will be reduced by 15% of the 1986 rate on the assumption that physician production and in-migration will be reduced by 15% in the United States.

Changing Assumptions About Physician Manpower Production. We built the spreadsheet so that assumptions about the future and options under the control of policymakers could be studied to determine their effect on manpower supply and need. For physician manpower production in the

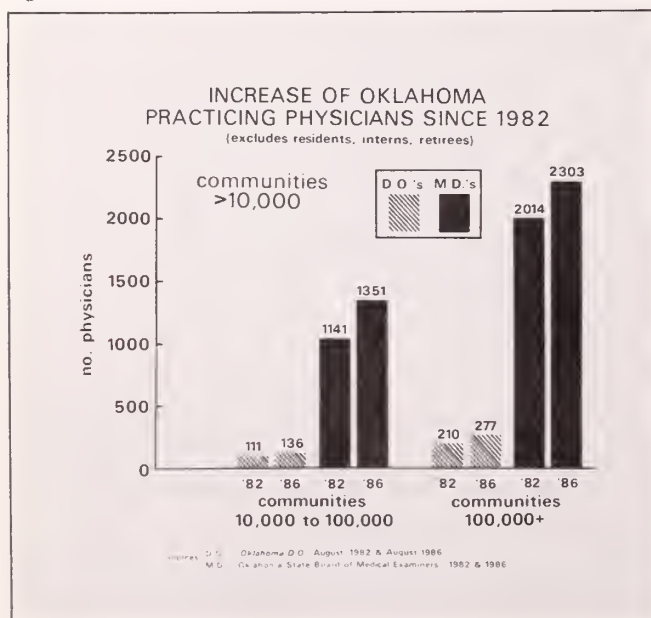
state-supported medical student programs, only the final graduate medical education output was considered. We assumed that reductions in medical student class size would be translated into a proportional reduction in the graduation of residents. Because the education of a physician varies from 5 to 12 years depending on the specialty, the impact of any reduction or increase in medical school entering class size will not influence the numbers of physicians entering practice for almost a decade.

For the analysis of this paper, we tested three manpower production scenarios: (1) No change from 1984 numbers of medical students or residents; (2) The Regents' recommended 8% reduction in OUCOM medical student enrollment in 1988 based on 1984 entering class size and an 8% reduction in OCOMS entering class in 1988 based on 1984 entering class size; (3) A 15% reduction in OUCOM enrollment and a comparable 15% reduction in the OCOMS entering class in 1988 compared to the 1984 entering class size.

Results

Table 2 demonstrates the 1986 Physician Manpower Estimate Model. Column 1 displays the GMENAC specialties. Column 2 shows the number of physicians practicing the specialty in Oklahoma in 1986. Column 3 shows the number of MD graduates from state-sponsored residency and fellowship programs in 1986. Column 4 indicates the number of osteopathic physician graduates in 1986. Column 5 shows the number of MD physicians who are estimated to take practice positions out of Oklahoma each year. Column 6 indicates the calculated number of osteopathic graduates who will leave the state after graduation each year. Column 7 indicates the number of physicians in each specialty who are estimated to enter practice in the state each year after completing training elsewhere. Column 8 indicates the number of physicians who are estimated to leave practice each year. Column 9 is the sum of columns 2 through 8 and is the estimated number of physicians in practice after one year. Column 10 is the HMO-adjusted GMENAC population-based physician needs for Oklahoma. The heading for column 10 reveals the population upon which the need is calculated and the percentage of the population served by HMOs. Column 11 is the difference between columns 10 and 9. It is the surplus (a positive number) or deficit (a negative number) of physicians for the specialty. Column 12 is the supply of physicians, expressed as a percent of need. The

Figure 4.



bottom line of column 9 shows the estimated supply ratio (156 physicians/100,000 population), and the bottom line of column 10 shows the estimated need ratio (186 physicians/100,000 population). The ratio is less than the GMENAC ratio (191/100,000 population), reflecting the percentage of the population served by the HMOs employing 120 physicians/100,000 population.

In 1987 Oklahoma remains undersupplied, with physician manpower having only 84% of its needs being met. Primary care needs will be met at 89%, secondary care at 74%, and tertiary care at 62%. The specialties showing a supply of less than 75% of need include: psychiatry (43%), child psychiatry (10%), hematology/oncology (39%), dermatology (64%), internal medicine (56%), gastroenterology (57%), infectious disease (37%), nephrology (53%), and pediatric specialties (10%-40%). Certain specialties, however, show more than 110% of need. They include osteopathic GP (156%), thoracic surgery (118%), cardiology (125%), family practice (111%), and neurosurgery (111%). These data are surprisingly different from the perceived national excess in medicine specialties. Figure 1 displays the estimated surplus and deficit of physicians by specialty in 1990.

The total number of physicians in each specialty fails to tell the full story of physician manpower in Oklahoma. Figure 2 is a map of Oklahoma with each of the 22 hospital trade areas outlined. In each trade area the percentage of the *Adjusted Service Based*

Needs for physician manpower currently supplied in the area is shown. Only three of the 22 trade areas have a physician supply greater than 85% of the estimated need for the area. These are Oklahoma City (110%), Tulsa (89%), and Bartlesville (89%). Six of the 22 trade areas have less than 50% of the adjusted service-based need for physician manpower. These are Idabel (33%), Shawnee and Durant (each

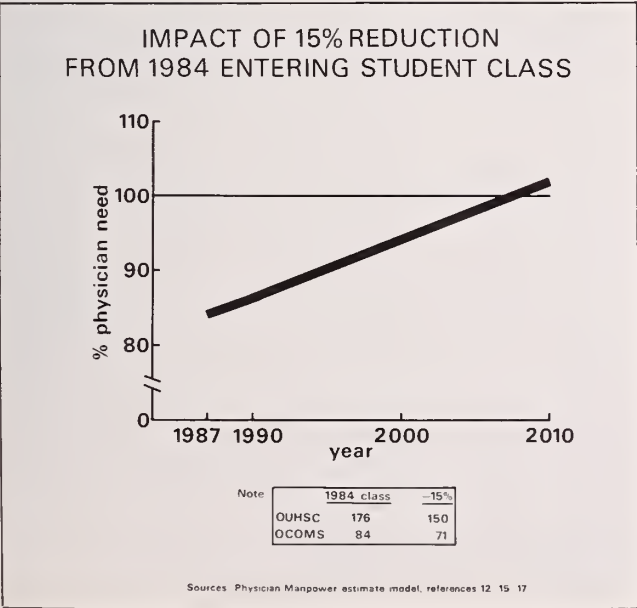
**These data are
surprisingly different
from the perceived
national excess...**

42%), Chickasha (44%), Elk City (46%), and Shattuck (49%). The supply of physicians in towns of 5,000 or less population is provided by 247 MD physicians¹⁶ and 142 DO physicians.¹⁴ In towns of 5,000 to 10,000 population, there are 238 MDs¹⁶ and 101 DOs.¹⁴ See figures 3 and 4.

Figure 5 demonstrates the effect on the total physician supply of manpower production scenario #3, a 15% reduction in both MD and DO class size.

Table 3 shows the projected surplus and deficit in certain specialties in 1990, 2000, and 2010 for scenario #3, a 15% reduction in MD and DO production in 1988 based on 1984 entering class size and no change in current intern/residency positions.

Figure 5.



Conclusions

1. An immediate 15% reduction in class size (based on 1984 entering class size of the University of Oklahoma College of Medicine and the Oklahoma College of Osteopathic Medicine and Surgery) is projected to cause the number of physicians in Oklahoma to reach the projected state need for new and total physicians by 2010.
2. Unless adjustments are made soon in the distribution by discipline of residency positions, the current problem of inappropriate mix of physicians by specialty will become more unbalanced.
3. Further efforts will be needed to assure more equal geographic distribution of physicians who are trained in appropriate specialty disciplines.

TABLE 3

PROJECTED OKLAHOMA PHYSICIANS SUPPLY AND NEED FOR 1990, 2000 & 2010

SPECIALTY	2 1986 MD & DO TOTAL PRACTICE 3233700	9 1990 EST. OKLA PHYS. SUPPLY	10 1990 NEEDS PHYS 3419200 15% IN HMO	11 1990 ESTIMATED OKLAHOMA PHYSICIAN SURPLUS DEFICIT	9 2000 EST OKLA PHYS SUPPLY	10 2000 NEEDS PHYS 3753300 20% IN HMO	11 2000 ESTIMATE OKLAHOMA PHYSICIAN SURPLUS DEFICIT	9 2010 EST OKLA PHYS SUPPLY	10 2010 NEEDS PHYS 4039600 25% IN HMO	11 2010 ESTIMATED OKLAHOMA PHYSICIAN SURPLUS DEFICIT
PMTC PRIMARY CARE										
FAMILY PRACTICE	885	948	831	117	1057	901	155	1165	959	206
OSTEOPATHIC G.P.	455	509	308	200	620	335	285	720	356	365
INTERNAL MEDICINE	502	559	952	-394	663	1033	-370	769	1099	-330
PEDIATRICS	270	306	410	-104	375	445	-69	444	473	-29
OB GYN	275	309	325	-17	370	353	17	433	375	57
TOTALS	2387	2631	2828	-197	3084	3067	17	3531	3261	270
PMTC SECONDARY CARE										
ANESTHESIOLOGY	217	260	273	-13	346	292	54	431	306	125
CARDIOLOGY	123	134	101	33	151	108	44	171	113	58
CHILD PSYCHIATRY	11	14	117	-103	20	125	-105	26	131	-105
DERMATOLOGY	56	62	90	-29	72	97	-25	83	101	-18
EMERGENCY MEDICINE	147	158	176	-17	176	188	-11	196	197	-1
GENERAL SURGERY	268	285	306	-21	312	327	-15	341	342	-1
HEMATOLOGY ONCOLOGY	43	54	117	-64	74	125	-51	95	131	-36
PREVENTIVE MED.	59	65	95	-30	74	102	-27	85	106	-21
OPHTHALMOLOGY	138	140	151	-11	141	161	-20	142	169	-27
ORTHOPEDIC SURG	167	180	197	-17	201	210	-9	224	220	4
OTOLARYNGOLOGY	74	81	104	-23	94	111	-18	106	116	-10
PATHOLOGY	122	139	176	-36	171	188	-16	205	197	8
PSYCHIATRY	212	230	501	-271	259	536	-277	290	561	-271
RADIOLOGY	238	256	234	22	288	250	37	318	262	56
UROLOGY	95	102	100	1	113	107	6	125	112	13
SECONDARY TOTALS	1970	2160	2738	-579	2495	2927	-432	2838	3065	-226
PMTC TERTIARY CARE										
ALLERGY	23	22	27	-5	19	28	-10	15	30	-14
ENDOCRINOLOGY	16	23	27	-3	38	28	10	54	30	24
GASTROENTEROLOGY	46	54	84	-31	68	90	-22	83	94	-12
INFECTIOUS DISEASES	10	13	29	-17	17	31	-14	22	33	-11
NEONATOLOGY	12	18	17	1	30	18	12	41	19	22
NEPHROLOGY	18	21	36	-15	27	38	-11	34	40	-6
NEUROLOGY	47	54	71	-18	67	76	-9	80	80	0
NEUROSURGERY	38	39	34	4	39	37	2	39	39	0
NUCLEAR MEDICINE	5	7	52	-45	12	55	-43	17	58	-41
PEDIATRIC ALLERGY	2	2	12	-10	1	13	-11	1	13	-12
PEDIATRIC CARDIOL.	5	5	15	-10	4	16	-12	3	17	-14
PEDIATRIC ENDOCRIN	0	4	10	-6	13	11	2	21	12	10
PEDIATRIC HEM. ONC.	3	5	21	-16	11	23	-12	16	24	-8
PEDIATRIC NEPH.	2	3	5	-2	3	5	-1	5	5	-1
PHYSICAL MED. REHAB.	15	14	42	-28	11	44	-34	8	46	-39
PLASTIC SURGERY	35	37	35	2	40	37	2	43	39	4
PULMONARY	33	43	47	-4	63	50	13	83	52	31
RHEUMATOLOGY	21	22	22	0	23	24	0	25	25	0
THORACIC SURGERY	30	35	27	8	46	28	18	56	30	27
TERTIARY CARE TOTALS	361	419	613	193	532	654	-122	646	685	-39
OTHER*	82	96		96	120		120	147		147
PRACTICING PHYSICIANS	4800	5306	6178	-873	6231	6648	-417	7162	7011	151
LICENSED RESIDENTS	580	580			444			444		
LICENSED PHYSICIANS	5380	5886	6178	-293	6675	6648	27	7605	7011	595
RES. .35 FTE PRACT.*	203	203			155			155		
TOTAL FTE PRACTICE	5003	5509	6178	-873	6386	6648	-417	7317	7011	151
PHYS 100000 POP**	166	172	181	-9	178	177	1	188	174	15
FTE PHYS 100000 POP***	155	161	181	-20	170	177	-7	181	174	8

*Each Resident is estimated to provide 35% of the productivity of a full time practicing physician. **Includes Residents

***Includes adjustment of 35% FTE for each resident.

Recommendations

- 1. Oklahoma health policymakers should, in the very near future, oversee a redistribution of the residency positions in the state so that the imbalance of physicians trained to the needs projected is corrected (Fig 1).
- 2. A minimum of three years postgraduate training should be provided in all postgraduate training positions.
- 3. The total number of graduate medical education positions should be reduced by 15% in 1992 from the 1987 total number.
- 4. The manpower numbers should continue to be monitored and updated by the Oklahoma State Regents for Higher Education and other interested groups.
- 5. Entering class size at Oklahoma medical and osteopathic schools should be adjusted to a number 15% lower than the 1984 entering class sizes, which will provide 177 physicians per 100,000 population in Oklahoma by the year 2000.
- 6. Entrance requirements should be essentially the same at the University of Oklahoma College of Medicine and the Oklahoma College of Osteopathic Medicine and Surgery.
- 7. State education and licensing policies should be adjusted to assure that incoming foreign medical graduates are equal in caliber to US medical graduates.

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News from the Oklahoma State Department of Health

Services to Special Needs Children

Note: The Oklahoma State Department of Health is devoting its space this issue to announcing an exciting new service for special needs children, their families, and the health professionals who provide services to them.

The Oklahoma Areawide Services Information System for the Handicapped (OASIS) will soon offer a unique statewide information and referral system for services and resources geared to assisting professionals and parents of high risk/handicapped children, including the mentally retarded and mentally ill. The system's catalogue of both public and private service providers is on-line with its toll-free number, 1-800-42-OASIS. Administrator of the project is Roger Sheldon, MD, chief of the Neonatology Section, Department of Pediatrics, University of Oklahoma Health Sciences Center. Project Director is Patricia S. Burns.

Needs Assessment of Oklahoma's Developmentally Delayed and Handicapped Infants, Toddlers,

Pre-School Children and their Families, recently published by the Oklahoma Commission on Children and Youth, included a statewide survey of professionals caring for high-risk and handicapped children. Physicians noted their lack of up-to-date information for advising parents on what facilities and services are available for their disabled children, the ages served by those services, and where the nearest services are located. Many physicians felt they did not have sufficient information about available resources to accurately refer a chronically ill or handicapped child and his or her family. This was especially true for nonmedical services, like parent training and support groups, medical equipment maintenance, or emergency transportation funds.

An important aspect of OASIS is to identify not only the government agency resources throughout the 77 counties, but also to learn about and emphasize local and private sector resources that serve the high-risk/handicapped child.

If you are interested in being listed as a resource for OASIS, or can identify people in your community as resources for high-risk/handicapped children, please contact the OASIS Office, 3 Nicholson Tower, Room 360, 940 NE 13th St, Oklahoma City, OK 73126, phone (405) 271-6302.

DISEASE	April 1987	TOTAL TO DATE		
		This Year	Last Year	5 Yr. Avg.
AMEBIASIS	1	3	4	5
CAMPYLOBACTER INFECTIONS	13	55	52	—
ENCEPHALITIS, INFECTIOUS	3	10	5	6
GIARDIA INFECTIONS	5	56	53	—
GONORRHEA (Use ODH Form 228)	980	3403	4152	4198
HAEMOPHILUS INFLUENZAE INVASIVE DISEASE	16	52	81	—
HEPATITIS A	33	118	109	148
HEPATITIS B	33	91	54	63
HEPATITIS, NON-A NON-B	5	17	17	—
HEPATITIS UNSPECIFIED	0	16	20	46
MEASLES (RUBEOLA)	0	1	4	1
MENINGITIS, ASEPTIC	6	18	14	16
MENINGITIS, BACTERIAL (non-meningococcal, non H. Influenzae)	5	21	26	24
MENINGOCOCCAL INFECTIONS	3	14	11	13
PERTUSSIS	2	31	21	39
RABIES (Animal)	2	7	20	44
ROCKY MOUNTAIN SPOTTED FEVER	3	4	5	4
RUBELLA	0	0	0	0
SALMONELLA INFECTIONS	27	76	116	88
SHIGELLA INFECTIONS	17	78	48	67
SYPHILIS (Use ODH Form 228)	11	52	62	63
TETANUS	0	0	0	0
TUBERCULOSIS	14	70	67	80
TULAREMIA	0	5	2	2
TYPHOID FEVER	0	1	1	1

Diseases of Low Frequency	Total to Date This Year
ACQUIRED IMMUNE DEFICIENCY SYNDROME	17
BRUCELLOSIS	0
LEGIONNAIRES DISEASE	5
MALARIA	2
REYE SYNDROME	1
TOXIC SHOCK SYNDROME	7

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OSMA elects new officers at Annual Meeting in OKC

The Oklahoma State Medical Association (OSMA) named a new slate of officers at its Annual Meeting May 1-3 in Oklahoma City.

M. Joe Crosthwait, MD, Midwest City, is the new president. Serving with him will be Ray V. McIntyre, MD, Kingfisher, president-elect; John R. Alexander, MD, Tulsa, vice-president; and James D. Funnell, MD, Oklahoma City, secretary-treasurer.

Also elected were Jerry L. Puls, MD, Tulsa, chairman of the OSMA Board of Trustees, and Lanny F. Trotter, MD, Stillwater, vice-chairman of the board.

Re-elected to two-year terms as delegates to the AMA were Ed L. Calhoon, MD, Beaver; Victor L. Robards, Jr., MD, Tulsa; Orange W. Welborn, MD, Ada; and James B. Eskridge III, MD, Oklahoma City.

James B. Pitts, Jr., MD, Oklahoma City, and Michael J. Haugh, MD, and George H. Kamp, MD, Tulsa, were re-elected as alternate delegates to the

AMA. Gary F. Strebel, MD, Oklahoma City, is the new alternate delegate. His two-year term begins in January.

Retaining their seats on the PLICO Board of Directors were C. Alton Brown, MD, Oklahoma City; Kenneth W. Whittington, MD, Bethany; C. S. Lewis, Jr., MD, Tulsa; John A. McIntyre, MD, Enid; and Billy Dale Dotter, MD, Okeene. Joining them is newly elected Tim K. Smalley, MD, Stillwater. □

Life Memberships get nod from OSMA Board of Trustees

Sixteen Life Memberships were approved by the Oklahoma State Medical Association (OSMA) Board of Trustees at their May 1 meeting in Oklahoma City.

The new Life Members are Donald D. Albers, MD; Sterling T. Crawford, MD; Rex Kenyon, MD; Joseph N. Kramer, MD; Haven Mankin, MD; and J. R. Stacy, MD; of Oklahoma City.

Also named were Edmond physicians Kent Braden, MD; John M. Carey, MD; and James S. Turner, MD.

The following were also designated Life Members: Curtis B. Cunningham, MD, Clinton; Samuel E. Dakil, MD, McAlester; Jess Hensley, MD, Arcadia; F. W. Hollingsworth, MD, El Reno; Wolfgang Karl Huber, MD, Norman; David C. Lowry, MD, Choctaw; and Lester I. Nienhuis, MD, Tulsa. □

OSMA
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Eye institute launches program to improve reporters' insight

Medical experts in a variety of specialties convened on May 29 at the Dean A. McGee Eye Institute in Oklahoma City to give their views on current topics of interest to the media and general public.

Some of the topics discussed were AIDS, bone marrow transplantation, heart disease, treatment of diabetic retinopathy, innovations in cataract surgery, and corneal transplants.

Speakers for the symposium were Thomas E. Acers, MD; Ronald O. Gilcher, MD; Robert B. Epstein, MD; Darryl R. Fisher, MD; Fenton M. Sanger, MD; David A. Flesher, MD; Wayne F. March, MD; Reagan H. Bradford, Jr., MD; Robert E. Nordquist, PhD; W. Stanley Muenzler, MD; and Hal D. Balyeat, MD.

Dr Balyeat, program director, says the local Medical Writers Symposium is patterned after a similar national symposium held annually in Washington, DC. Course participants received updates on many topics of interest. Additional benefits were to give writers and reporters new ideas

about topics and afford them some background material on which to base stories.

A surgeon at the institute, Balyeat thinks the most longlasting benefit will be the establishment of a panel of physicians who will be available to provide future information to course participants on a variety of medical subjects.

When a journalist is preparing a story and needs background information or wishes to verify the accuracy of a story, the participant can call the Public Information Office at the institute, Balyeat explained. A panel member, an authority on the subject matter, will be contacted, and a telephone interview with the journalist will be arranged. This will allow easy access to updated, accurate information, he continued.

"We are deeply indebted to the Oklahoma Lions Eye Bank for financially underwriting much of the cost of the symposium," stated Balyeat. "I would hope this symposium will become an annual event, with future topics suggested by the course participants."



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Dennis Karasek, M.D.
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SB 183 becomes law. Oklahoma Governor Henry Bellmon signs SB 183, a tort reform measure backed by the OSMA, into law on May 7. With him, l to r, are: Otie Ann Carr, OSMA lobbyist; Richard Huddleston, PLICO lobbyist; Rep. Loyd Benson (D-Frederick), co-author of the bill; Larry L. Long,

MD, speaker of the OSMA House of Delegates; C. Alton Brown, MD, president of PLICO; Sen. Tim Leonard (R-Beaver), co-author; David Bickham, OSMA executive director; and Rod Frates, president of C. L. Frates & Company.

Bargain for state golfers


Golfing can be good for you and for the lung association

Twenty-three state golf courses are taking part in the American Lung Association of Oklahoma Golf Privilege Card offer this year. For just \$10 a cardholder can play 18 holes on each of the courses between June 1, 1987, and October 31, 1987.

"This is the fourth year we have offered the card," says John G. Rogers, ALA/O executive vice president, "and it gains in popularity each year. Many people buy more than one card. Sometimes an office or business will purchase a block of 15 to 20 cards." Many people also buy the cards to give as gifts, he adds.

In addition to being an excellent bargain for all golfers, cardholders are helping support important programs in the fight against lung disease. "We have programs for people of all ages throughout the state," says Rogers. "The golf courses that are participating in this offer are helping support lung research, public education, and professional training. We appreciate their community concern."

Some restrictions may apply to the use of the

card. For information on how to purchase a golf privilege card, contact the American Lung Association of Oklahoma, PO Box 53303, Oklahoma City, OK 73152-3303, (405) 524-8471. 

DEATHS

Scott Allen Morris, MD 1954 - 1987

Scott Allen Morris, MD, Edmond, died May 24, 1987. An anesthesiologist, Dr Morris was born in Crane, Tex. After two years of active duty in the US Marine Corps, he enrolled at the University of Oklahoma, where he was graduated from the College of Medicine in 1981. He served his internship and residency at the Oklahoma Teaching Hospitals in Oklahoma City.

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Doctors, Uncle Sam wants you . . . to help aliens become citizens

On November 6, 1986, President Ronald Reagan signed Public Law 99-603 providing for legalization of aliens who are in the United States illegally. There will be an estimated 90,000 to 100,000 persons applying for citizenship in Oklahoma alone.

One of the requirements for such application is a physical examination by a designated civil surgeon.

To be designated a civil surgeon, a physician must send a request to District Director Ronald C. Chandler, Immigration and Naturalization Service, 6A21 Federal Building, 1100 Commerce, Dallas, Texas 75242.

Currently there are only five designated civil surgeons in the State of Oklahoma.

IN MEMORIAM

1986

<i>Marianne Elsbeth Kosbab, MD</i>	<i>June 13</i>
<i>William W. Rucks, Jr., MD</i>	<i>June 27</i>
<i>Ralph A. Smith, MD</i>	<i>July 27</i>
<i>Howard D. Tuttle, MD</i>	<i>August 3</i>
<i>Welborn W. Sanger, MD</i>	<i>September 19</i>
<i>William Carl Ewell, MD</i>	<i>September 20</i>
<i>Marcella Steel, MD</i>	<i>October 1</i>
<i>Terry Dwight Leming, MD</i>	<i>October 13</i>
<i>William Pat Fite, Jr., MD</i>	<i>October 30</i>
<i>Samuel Jackson McDaniel, MD</i>	<i>November 2</i>
<i>Iron Hawthorne Nelson, MD</i>	<i>November 12</i>
<i>John Robert Walter Spencer, MD</i>	<i>December 4</i>

1987

<i>Edward Leon Moore, MD</i>	<i>February 14</i>
<i>Ralph Cameron Emmott, MD</i>	<i>February 16</i>
<i>James Laurel Haddock, Jr., MD</i>	<i>February 19</i>
<i>Donald J. Blair</i>	<i>March 16</i>
<i>Eldon Clyde Mohler, MD</i>	<i>March 21</i>
<i>Paul Lewis Nave, MD</i>	<i>March 26</i>
<i>George Michael Willkom III, MD</i>	<i>March 30</i>
<i>Odis A. Cook, MD</i>	<i>April 4</i>
<i>Victor Gary Anderson, MD</i>	<i>April 10</i>
<i>Edgar W. Young, Jr., MD</i>	<i>April 12</i>
<i>Paul Newman Atkins, Jr., MD</i>	<i>April 20</i>
<i>Scott Allen Morris, MD</i>	<i>May 24</i>

Program includes Oklahomans

AMA offers state doctors chance to play politics in Washington

The American Medical Association (AMA) will kick off its 1987 Political Education Conference in Washington, DC, on September 16; Oklahoma doctors are invited to participate.

Oklahoma Medical Political Action Committee (OMPAC) Director Robert W. Baker III will be a featured speaker in the workshop "Understanding the Medical PAC Process," and Norman L. Dunitz, MD, immediate past president of the Oklahoma State Medical Association (OSMA) will appear in the AMPAC video *Medicine: Playing Politics for the Future*.

Noted television commentator John McLaughlin of "The McLaughlin Group" will be the headline speaker in a program designed to teach how one

person can make a difference in today's political arena. In addition to the PAC workshop, participants will learn about creating volunteer groups of medical activists, generating grass roots participation in 1988, and balancing time between medicine and politics.

Also scheduled is a private Congressional Reception on Capitol Hill offering the chance to meet and greet elected representatives.

The conference, sponsored by the AMA Division of Political Education, will run Wednesday and Thursday, September 16 and 17, 1987. For registration information call Robert Baker at OSMA headquarters, (405) 843-9571 or 1-800-522-9452. □

BOOK SHOP

The Fragile-X Syndrome: Diagnosis, Biochemistry, Intervention. Edited by R. J. Hagerman, MD, and P. M. McBogg, MD. Spectra Publishing, Inc: Dillon, Colorado, 1983. Pp 239 with 50 illustrations. \$16.95 paperback, \$26.46 hardback.

This book represents the collaborative works of fifteen authors of diversified specialties ranging from persons in the medical sciences, such as genetics, cytogenetics, and biochemistry, to those involved in the psychosocial and ancillary aspects of care, namely psychiatry, child development, speech and language pathology, and occupational therapy. The purpose is to present the reader with a complete "comprehensive care" approach to the diagnosis and the management of the patient with fragile-X syndrome. Most of the authors are affiliated with the University of Colorado School of Medicine and/or the Denver Children's Hospital — a group that has an impressively large experience in this particular disorder.

The book is divided into nine chapters. Chapters are included on the historical overview (Turner), the clinical features (Hagerman, Smith, and Mariner), the cytogenetics (McGavian and Maxwell), the heterozygous female (Hagerman and Smith), genetic counseling (Smith and Berry), the biochemistry (Taylor and Hagerman), behavioral dysfunction (Levitas, McBogg, and Hagerman), and the treat-

ment and intervention (Levitas, Braden, Van Norman, Hagerman, and McBogg) of the patient with the fragile-X syndrome. The well-known professor of pediatrics and genetics, Dr Arthur Robinson, also of the University of Colorado School of Medicine, provides an introduction.

This book is timely in that the amount of material published on this subject has increased immensely over the past few years, resulting in a large volume of what often seems unrelated and even conflicting information. The authors of this book have done an excellent job of collating and summarizing the literature to date, and they have added much of their own works and insights.

In general this book is targeted toward a "non-specialist" audience. More than adequate background information is provided, such that anyone with a solid background in the basic medical sciences could easily pick up this book, having only cursory knowledge of the subject matter, and finish it with a solid core of knowledge of the current status of the medical progress in regards to the fragile-X syndrome. A notable exception, however, is the chapter on biochemistry which, while well written, seems to be out of proportion to the rest of the book both in its scope and in its in-depth nature, although granted this is the least well established area of knowledge in the fragile-X syndrome. (continued)

Book Shop (continued)

This book provides an excellent overview of the fragile-X syndrome, which is becoming increasingly more apparent as a disorder of major importance. (As the authors themselves point out, it is the second most common identifiable cause of mental retardation, second only to the Downs syndrome.) I would strongly recommend this manuscript for the reference library of any health care professional, especially those involved in primary care, as an introductory reference source to what will undoubtedly be shown to be one of the major health problems in both children and adults.

G. Bradley Shaefer, MD
Oklahoma City

Oklahoma: A History of Five Centuries. 2nd Edition. By Arrell Morgan Gibson. Norman: University of Oklahoma Press, 1981, pp 316, price \$17.50.

In 1965, Professor Arrell M. Gibson, a distinguished historian at the University of Oklahoma,

first published *Oklahoma: A History of Five Centuries* as a textbook. This is a revised edition, which has been also updated and enlarged.

The author first provides a geographical overview. The text moves chronologically. A highlight is the section on prehistoric times, which contains an interpretation of the period beginning with the Clovis man and the Spiro populace. Stories are related of the Plains Indians, the European explorers, the Five Civilized Tribes, the Civil War, and permanent white settlement; interwoven with these is the economic and political development of the area. While the coverage extends more than 500 years, the major focus is on the nineteenth century. The book also portrays the state's political and economic history, particularly over the past 80 years. The diversity and complex nature of the state's history is clearly pointed out.

Readers looking for an up-to-date history of Oklahoma will find it here.

Harris D. Riley, Jr., MD
Oklahoma City

Oklahoma Memories. Edited by Anne Hodges Morgan and Rennard Strickland. Norman: University of Oklahoma Press, 1981. Pp 336, illustrated, \$16.95 hardbound, \$8.95 softbound.

Oklahoma Memories describes significant events in the lives and careers of a variety of Oklahoma citizens. The 27 accounts describe personal anecdotes and experiences which cover the period from 1866 to 1978 and are authored by persons of all races living in Oklahoma.

The remembrances begin with "Christmas Time in Indian Territory" by Alice Mary Robertson, the second woman elected to the Congress of the United States, and extend to the experiences of Colonel Robinson Risner in a Vietnamese prison camp. In introductory or head notes the editors establish the historical perspective of each article and provide appropriate biographical sketches of the author. However, the editors allow the original writers to retain their viewpoints and opinions. The various pieces describe how historical events such as the land runs, the arrival of the railroads, statehood, agriculture, oil booms, and the depression affected the lives of individuals.

This is a unique and interesting approach to Oklahoma history which most readers will find of interest.

Harris D. Riley, Jr., MD
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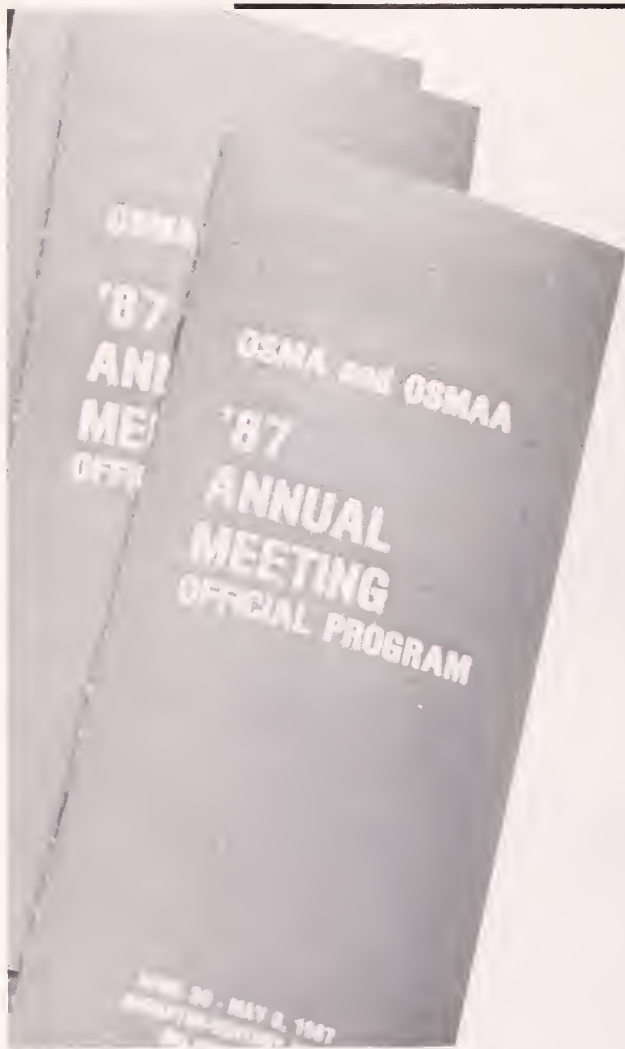
PROCEEDINGS

OKLAHOMA STATE MEDICAL ASSOCIATION
ANNUAL MEETING • MAY 1-3, 1987



SHERATON CENTURY CENTER

OKLAHOMA CITY



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Photographs by Susan Harrison and Mike Sulzycki

OSMA House of Delegates REPORT OF THE PRESIDENT

Norman L. Dunitz, MD

Mr Speaker, members of the House of Delegates, and guests.

Certainly, one of the most challenging yet one of the greatest honors I have ever had, has been the opportunity to serve as your President during this past year. The challenges and activities of our association have made my term difficult but also very rewarding.

One of the brightest spots has to be the efforts of our OSMA Auxiliary. They are to be commended for their numerous efforts but especially for their Medicine Day at the State Capitol. Medicine Day afforded our profession with one of the greatest shows of strength ever visualized at this State Capitol. I commend each county society and their members for donating their time to travel to Oklahoma City and participate.

As your President, I was able to visit with each member of the Oklahoma Congressional Delegation during two trips to Washington, DC, as well as locally. Noteworthy happenings of these visits included Congressman McCurdy's willingness to author and successfully obtain an amendment to delay the CHAMPUS bidding. This delay would not have been achieved without our own federal relations program. This has benefited not only members of our state who deal with CHAMPUS, but also doctors throughout America. We obtained Congressman Jones's support for lifting the fee freeze and for eliminating the participating/non-participating program. However, these changes, although successful in name, were in effect relatively disappointing. Later, we have been able to convince six of our eight congressmen to become cosponsors of concurrent resolutions aimed at opposing mandatory assignment and opposing the Administration's proposal to place radiologists, pathologists, and anesthesiologists under the DRGs system. Granted, many of those activities may merely be delaying the inevitable; but hopefully some intelligent changes will take place. Our congressional delegation has been most cooperative with our physicians.

Early in my term I was given the opportunity to appoint two physicians to the newly created AMA Young Physicians Section. Our Oklahoma strength in the American Medical Association, at a new level, was exemplified when our two appointees, Lee Newcomer and Robert Bowman, were both elected to represent the entire AMA section in the House of Delegates. Special congratulations are certainly in order for both Dr Newcomer and Dr Bowman.

On the communications front, throughout this past year, I have participated with radio station KTOK, here in Oklahoma City, in an effort to strengthen the medical



*If there is one legacy
I would like to see ...
it is
our increasing awareness
and involvement in
our legislative process ...*

profession's audience statewide through monthly radio spots. Also, the OSMA has produced the film, *Preserving Tradition, Embracing Change*, aimed at statewide public television and throughout the country. For this I commend Dr Joe Crosthwait for his leadership in this project. His efforts have produced and distributed an excellent film.

During the 1986 House of Delegates meeting, this House requested a five percent budget reduction. I am happy to report that through everyone's willingness to cooperate, this reduction, it would appear, will have been attained. In light of this reduction, it should also be noted that no dues increase is proposed this year. I certainly commend our OSMA staff and especially David Bickham for the ability to maintain excellent association activities during a period of diminished financial demands. I cannot emphasize to you enough the high quality of work and management carried out by our OSMA office staff.

As I know you are aware, our state is experiencing economic shortfalls at record levels. The Governor and the Legislature are examining many areas to reduce the shortfall. However, one proposal, the elimination of the Tulsa Medical College, I feel must be strongly opposed. Under Dean Tomsovic's guidance, this school has benefited this state and particularly the Tulsa indigent community and must be allowed to continue to operate as the fine educational institution it has become.

Also, in the field of medical education, I have continued to support your mandate that the surplus of physicians must be controlled. With our OU Medical School Dean, Dr Kassebaum, there have been guidelines set to discourage the diminution of the standards of ability required for acceptance into the school of medicine. At present, an 8% reduction in class size has been set; possibly a 15% reduction may be attained. In the same vein, I have supported the concept that increasing the total residency positions in our training programs is counterproductive and not compatible to the health and best interests of our state's medical profession.

I have worked with the Workman's Compensation Administration judge to develop a fee guideline as mandated last year by our state legislature. This is still far from ideal but, I am assured, still open to negotiation. It is much superior at present than it was in the original proposal.

Finally, on the subject of tort reform. This year's

activities saw the association combine forces with the Oklahoma State Chamber of Commerce. Under the direction of recently deceased Don Blair, Oklahomans Against Lawsuit Abuse went to painstaking efforts to achieve our goals. Don's efforts are appreciated, and he will be deeply missed. Our final product, Senate Bill 183, falls far short of ideal tort reform, but it is a definite improvement and another step forward in the direction toward the reform we so badly need. One of our really great disappointments this past year was our inability to even obtain stronger legislation, something almost in our grasp, but finally torpedoed by merely one state senator. We *must not* give in to the special interests of a few legislators. This will continue to take an all out effort and definitely include a strong political action posture.

Recognizing the importance of political action throughout the country, the American Medical Political Action Committee funded and produced a film in which I was asked to participate. This is an effort to enlist all physicians in these activities, both through our own political action groups and individually.

(show AMPAC tape)

This videotape you have just seen is available for your county meetings at no cost. Also, on behalf of OMPAC, you should note that Dr Larry Long and Robert Baker will be happy to visit each of your counties and make a political action presentation.

In closing, if there is one legacy I would like to see remaining as a result of this year, it is our increasing awareness and involvement in our legislative process and affairs at every level.

Dr Crosthwait, this past year it has been my pleasure to represent the finest medical association in America. I am happy to present to you an association ready to support you in your efforts. I know that we will all benefit from your guidance and leadership this coming year. On behalf of my wife, Annette, and myself, I can only say, thank you.

Respectfully submitted,
Norman L. Dunitz, MD
President

OSMA House of Delegates REPORT OF THE PRESIDENT-ELECT

M. Joe Crosthwait, MD

Ladies and Gentlemen of the OSMA House of Delegates . . .

I'm mad as hell and I'm not going to take it anymore!

With everything that is happening to medicine today, I am sure most physicians have thought — if not actually uttered — those words.

We all know that there are serious problems — an optimist might say challenges — facing our profession. Rules, regulations, competition, loss of control, advertising, alternate delivery systems, DRGs, HMOs, IPAs, PPOs, PROs, and the list goes on and on. The greatest medical care system in the world was not developed or nurtured by HMOs, PPOs, IPAs or any other alphabet soup.

I wonder how many of you — particularly those who have been in practice for more than 20 years — have ever experienced the frustration, indeed the alienation, I felt at a recent medical staff meeting. Our discussion that night was not on how to better care for our patients, but on how best to cope with the many obstacles to that care. We sounded more like insurance men, lawyers, even government bureaucrats, than we did physicians as we talked about gatekeepers, co-pays, and deductibles; about the Medicare regulations contained in OBRA, COBRA, and SOBRA, and about the malpractice insurance crisis.

I left that meeting honestly wondering whether or not I had become an anachronism. Had my time passed? I felt more like a businessman than a physician that night. This is not why I became a doctor, I thought.

Let us never forget that we became physicians to heal, to comfort those who are ill or injured. The greatest medical care in the world was developed in an uncontrolled atmosphere, and the recipe for the practice of medicine was not propagated by a PSRO, PRO, or any other third party.

Many physicians today are "mad as hell." But if we are angry for ourselves, our anger is tragically misdirected.

How is it possible to be angry when we are practicing our profession — that is, when we are actually treating and counseling and healing our patients?

Medicine offers such special satisfaction.

First, we are constantly offered intellectual stimulation as we diagnose our patients, seek consultations with our peers, and share our knowledge and experience with residents and medical students.

In most professions or businesses, the goal is to one-up the competition, to keep trade secrets. It is only in medicine where ethics demand that discoveries be shared immediately with colleagues for the good of mankind.

Providing sound financial or legal advice, building the



*Like most physicians,
I am truly perplexed
at the decline in
our profession's image.*

better mousetrap, devoting your life to politics or public service, or simply giving an honest day's work for a day's pay, are all honorable, necessary, worthwhile endeavors.

But they can never offer the satisfaction that we as physicians experience every day by bringing a new life into the world, by reassuring parents that their child is going to get well, by comforting the families of our terminally ill and helping them through this very difficult period.

Like most physicians, I am truly perplexed at the decline in our profession's image.

The body of medical knowledge has increased geometrically since I graduated from medical school. You

***If our patients
are not our allies —
our staunchest allies —
then all is lost.***

and I can do so much more for our patients than ever before. Our technology, our science, and our skills have improved so very much.

Yet we are sued more often, and polls show the public continues to lose confidence in the profession.

"I'm mad as hell and I'm not going to take it anymore."

Perhaps the public — our patients — perceive us as being angry for ourselves.

We complain — rightly — of how rules and regulations inhibit our ability to practice and add to the cost of running an office. Our patients just see anger in our frustrations.

Somehow the operational frustrations of the modern medical practice have made adversaries of some doctors and their patients.

As I begin my year as president of the Oklahoma State Medical Association, I will set as a goal the reversal of this trend. If our patients are not our allies — our staunchest allies — then all is lost.

We have all worked hard to become physicians. We should take pride in our accomplishment and celebrate the good work that we do. We must convey and share this joy and pride in our profession with our patients because we entered medicine not to help ourselves but to help others.

Bring your concerns, your frustrations, your anger to your county society meeting, to your state medical association, or to the AMA.

These are the places to get mad, to get involved, to work together for medicine's future.

But let our offices be sanctuaries where our patients come for comfort and relief and we, the physicians, think only of how best we can minister to the needs of others.

This year let's commit ourselves to making our patients our allies. This year let's remember the satisfaction and return the joy to the practice of medicine.

Although each of us has our own agenda, cannot we agree on one agenda — to protect the greatest health care system in the world? Cannot we be unified in this endeavor? With unity we can and will prevail. Without unity we shall surely fail.

Thank you for your trust in me. I ask for your suggestions and pledge to do my best during my year as OSMA president.

Respectfully submitted,
M. Joe Crosthwait, MD



Minutes

OSMA House of Delegates

OPENING SESSION

Friday, May 1, 1987, 2:00 PM

I. Call to Order and Opening Remarks

The House of Delegates convened its 81st Annual Session at the Sheraton Century Center, Oklahoma City, Oklahoma, on May 1, 1987. The Speaker, Larry L. Long, MD, called the meeting to order at 2:10 PM.

II. Invocation

The invocation was delivered by Elvin M. Amen, MD, Past President, Bartlesville.

III. Introductions

Doctor Long introduced those at the head table: Thomas N. Lynn, MD, Chairman, Board of Trustees; Norman L. Dunitz, MD, President; Robert J. Perryman, MD, Vice-Speaker of the House; David Bickham, Executive Director, OSMA; Ann McWatters and Susan Meeks, Recording Secretaries.

Doctor Long introduced the following special guests: Mr. Kevin Walker, AMA Medical Society Relations Officer; Rick Ernest, Executive Director, Oklahoma County Medical Society; Paul Patton, Executive Director, Tulsa County Medical Society; Kelsey Walters, President, OSMAA; Julie Weedn, President-Elect, OSMAA; Warren L. Felton, MD, Medical Director of the Oklahoma Foundation for Peer Review; and Cyndy Alsup and Ruth Walsh, medical students.

IV. Approval of the Minutes of the 1986 Annual Meeting

It was moved that the House accept the minutes of the 1986 Annual Meeting. The motion was seconded and approved.

V. Auxiliary Report

Doctor Long recognized Mrs. Kelsey Walters, Auxiliary President, who presented her report, which is included and made a part of the official minutes.

Mrs. Walters stated that this was a year of "firsts" in many ways for the Auxiliary — the first male county president-elect was elected this year; a new county society in Jackson County was organized; and the first Medicine Day was held at the State Capitol.

Mrs. Walters thanked the doctors for their support during the past year. Mrs. Walters introduced Julie Weedn, president-elect, who spoke about next year's challenges.

VI. AMA-ERF Presentations

Mrs. Walters introduced "K" Caldwell who presented the following checks to the three medical colleges in Oklahoma:

\$28,202.67 was presented to William Hughes, MD, on behalf of the University of Oklahoma College of Medicine, Oklahoma City;

\$1,420.70 was presented to Edward J. Tomsovic, MD, Dean of the University of Oklahoma Tulsa Medical College, Tulsa;

\$3,965.00 was presented to Oral Roberts University. (A representative was not present to receive this amount.)

VII. Presentation of Awards

At this time, Doctor Long presented Kelsey Walters with the proclamation from Governor Henry Bellmon proclaiming February 18, 1987, as Medicine Day in Oklahoma.

Mrs. Walters was very grateful. She especially expressed gratitude to Jeannie Drake, Nadine Nickeson, and Jeary Seikel, Auxiliary members, who worked so hard on the Medicine Day project. She also thanked all the doctors, spouses, and friends of medicine who attended Medicine Day.

Doctor Long introduced Mary Ann Deen, Past Auxiliary President, who presented bound volumes of the OSMA JOURNAL to Mrs. Walters.

Next Doctor Long recognized Donald L. Brawner, MD, JOURNAL Editor, who presented bound volumes of the JOURNAL to Norman L. Dunitz, MD, OSMA President.

Doctor Brawner then presented the Charlotte S. Leebron Memorial Trust Award to Samuel Sepkowitz, MD, for his article "Improvement in the Birth Weight Distribution Among White Newborns in a Community Hospital." The article appeared in the May 1986 issue of the JOURNAL. Doctor Sepkowitz was presented a check in the amount of \$500.00.

Doctor Sepkowitz thanked everyone for this great honor.

Doctor Long introduced Mr. Jerry Herigon, from Sandoz Pharmaceuticals, who presented a check in the amount of \$500.00 to Susan Harrison, JOURNAL Managing Editor, who accepted it on behalf of the Editorial Board and the JOURNAL staff. The award is for the outstanding state medical journal published in 1986.

Ms. Harrison thanked everyone, saying that this is a very great honor.

Doctor Long stated the Executive Committee voted at its meeting the previous afternoon that Ms. Harrison should keep the \$500.00 award.

At this time Doctor Long mentioned the Special Memorial Resolution in honor of Don Blair in Reference Committee I. He introduced Ed Calhoon, MD, Beaver, to address the House regarding the Resolution. Doctor Calhoon spoke of his acquaintance with Mr. Blair and of the respect for Mr. Blair at the AMA.

Doctor Calhoon requested that the OSMA House of Delegates approve this Resolution unanimously and that it be transmitted to Mr. Blair's widow and family.

Doctor Long read the last *Resolve*:

Resolved, That the OSMA Outstanding Layman Award be henceforth known as the "Donald J. Blair Friend of Medicine Award," as an eternal reminder of the gratitude of Oklahoma physicians for his contributions to Oklahoma Medicine.

Doctor Long made the announcement that balloting had been done at the Board of Trustees meeting for the Outstanding Layman Award. Lawrence W. Rember, Oklahoma City, has been elected for this honor. The award will be presented to Mr. Rember at the August Board of Trustees meeting.

VIII. Remarks of the Speaker

Doctor Long appointed the following committees to assist in the conduct of the meeting:

Parliamentarian

Floyd E. Miller, MD, Tulsa

Credentials Committee

Roland A. Walters, MD, Oklahoma City, Chairman
Carl H. Guild, MD, Bartlesville

Tellers

Robert J. Weedn, MD, Duncan, Chairman
E. N. Scott Samara, MD, Oklahoma City
Thomas Lowrey, MD, Yukon

Sergeant-at-Arms

Warren L. Felton II, MD, Oklahoma City



Reference Committee I

Howard B. Keith, MD, Shattuck, Chairman
Irwin H. Brown, MD, Oklahoma City
Frank K. Buster, MD, Cheyenne
Henry H. Modrak, MD, Tulsa
Ronald H. Wright, MD, Oklahoma City
Bruce W. Walters, MD, Norman
John Alexander, MD, Tulsa

Reference Committee II

John A. Blaschke, MD, Oklahoma City, Chairman
Donald R. Carter, MD, Oklahoma City
Frank W. Clark, MD, Ardmore
Arthur E. Schmidt, MD, Oklahoma City
Robert White, MD, Stillwater
Boyd Whitlock, MD, Tulsa

Reference Committee III

William C. Stone, MD, Tulsa, Chairman
Marvin D. Peyton, Oklahoma City
Jimmie K. Jackson, Oklahoma City
Walter Gary, MD, Tulsa
Philip Bryan, MD, Miami
Theodore Brickner, MD, Tulsa
Thomas Rhea, MD, Idabel

Doctor Long asked that everyone wear their name badges.

Announcement was made that there will be a recess for delegate caucuses after the President's Report.

IX. President's Report

Doctor Long introduced Norman L. Dunitz, MD, who presented the President's Report.

He referred to the success of Medicine Day at the State Capitol; his trips to Washington, DC, to visit with the Oklahoma Congressional Delegation; and the AMA Young Physicians Section. Doctor Dunitz commended Doctor M. Joe Crosthwait for his leadership regarding the OSMA film *Preserving Tradition, Embracing Change*.

Doctor Dunitz showed the AMA-AMPAC recruitment film and announced the film is available to be shown at any meetings. Doctor Dunitz stated that Doctor Larry Long and Robert W. Baker of the OSMA staff will be happy to attend county society meetings to make presentations regarding OMPAC.

Doctor Dunitz stated that he would like to see a continuing increased awareness and involvement in our legislative process and affairs at every level.

Doctor Dunitz thanked everyone for their support this past year.
[The complete text of Dr Dunitz's report appears on page 459.]

X. Recess

At 3:15 PM, the House recessed to allow the county medical societies to caucus for trustee nominations. The House reconvened at 3:30 PM.



Samuel Sepkowitz, MD, Oklahoma City, holds the \$500 he received as winner of the Charlotte S. Leebron Memorial Trust Award. His article "Improvement in the Birth Weight Distribution Among White Newborns in a Community Hospital" was named the most worthy scientific paper published in the OSMA JOURNAL in 1986.

XI. Nominations for Elections

Doctor Long announced that the floor was open for nominations and only one brief seconding speech would be allowed per nomination.

The following were nominated for the respective officer and trustee positions:

President-Elect (one-year term of office) — Ray V. McIntyre, MD, Kingfisher.

Vice-President (one-year term of office) — John R. Alexander, MD, Tulsa.

Secretary-Treasurer (two-year term of office) — James D. Funnell, MD, Oklahoma City.

Delegate to the AMA (Position III) — Ed L. Calhoun, MD, Beaver.

Delegate to the AMA (Position V) — Victor L. Robards, Jr., MD, Tulsa.

Delegate to the AMA (Position VI) — Orange M. Welborn, MD, Ada.

Delegate to the AMA (Position VII) — James B. Eskridge III, MD, Oklahoma City.

Alternate Delegate to the AMA (Position III) — Arnold G. Nelson, MD, Midwest City, and Gary F. Strebel, MD, Oklahoma City.

Alternate Delegate to the AMA (Position V) — James B. Pitts, MD, Oklahoma City.

Alternate Delegate to the AMA (Position VI) — Michael J. Haugh, MD, Tulsa.

Alternate Delegate to the AMA (Position VII) — George H. Kamp, MD, Tulsa.

At this time Doctor Long recognized Thomas N. Lynn, MD, for his service to the OSMA as Chairman of the Board of Trustees during 1986-1987. Doctor Long also recognized Doctors Rollie Rhodes, Tulsa; Thomas Rhea, Idabel; and William Newland, Altus. Doctor Rhodes has served as Vice-Chairman of the Board of Trustees and Doctors Rhea and Newland have served as Trustees.

Trustee (District VI) — Raymond L. Cornelison, MD, Midwest City.

Alternate Trustee (District VI) — Sara R. DePersio, MD, Oklahoma City.

Trustee (District XI) — No nomination was made for this Trustee position.

Alternate Trustee (District XI) — Robert E. Engles, MD, Durant.

Trustee (District XII) — James V. Miller, MD, Ardmore.

Alternate Trustee (District XII) — Gary Paddack, MD, Ada.

Trustee (District XIII) — William S. Harrison, MD, Chickasha.

Alternate Trustee (District XIII) — Robert J. Weedn, MD, Duncan.

Trustee (District XIV) — No nomination was made for this Trustee position.

Alternate Trustee (District XIV) — Jeffry Lester, MD, Mangum.

Nominations for the PLICO Board of Directors (3-year term) were held at this time. The Board of Trustees heard nomination recommendations from the PLICO Board. An additional name was presented and accepted at the Board of Trustees meeting.



Tulsa doctors Theodore J. Brickner, Jr., MD, and Charles K. Harmon, MD, work in the House of Delegates. Dr Harmon is vice-president of the Tulsa County Medical Society.

The slate of nominees is as follows:
 Incumbents: C. Alton Brown, MD, OKC
 Kenneth W. Whittington, MD, Bethany
 C. S. Lewis, Jr., MD, Tulsa
 John A. McIntyre, MD, Enid
 Edward K. Norfleet, MD, Vinita
 Billy Dale Dotter, MD, Okeene
 Nominees: Robert A. Breedlove, MD, Stillwater
 Tim K. Smalley, MD, Stillwater
 (Doctor Smalley's name was presented at the Board meeting.)

The motion was made and seconded to accept this slate of nominees.

There being no other nominations, the nominations were declared closed.

At this time, Doctor Long turned the meeting over to Robert G. Perryman, MD, Vice-speaker of the House of Delegates.

XII. Report of the Chairman of the Board

Doctor Perryman recognized Thomas N. Lynn, MD, Chairman of the Board of Trustees. Doctor Lynn reviewed some of the proceedings from the Board of Trustees meeting.

Jerry R. Puls, MD, Tulsa, was elected the new Board of Trustees Chairman and Lanny F. Trotter, MD, Stillwater, was elected the new Vice-Chairman. These physicians were elected by acclamation.

The Board approved the following late items to be brought to the House: Return to Reason Coalition Report; a Memorial Resolution for Don Blair (late resolution); a Commendation Resolution for the OSMA JOURNAL (late resolution); Late Resolution 14 — "Malpractice Sales Commissions Paid by PLICO"; and Late Resolution 15 — "AIDS Education."

XIII. Report of the Secretary-Treasurer

Doctor Lynn recognized Raymond Cornelison, MD, Secretary-Treasurer of the OSMA. Doctor Cornelison referred to his report included in the handbooks.

He stated that the OSMA Committee on Appropriations and Auditing had reviewed and concurred with the financial audit report.

Doctor Long talked about the 1987 budget, stating that OSMA's assets are up one and one-half million dollars. He stated that Council expenses and annual meeting expenses are down. The OSMA has carried out the directive from the 1986 House of Delegates that there be a five percent reduction in expenses.

Doctor Cornelison stated he has enjoyed serving as Secretary-Treasurer the past four years, but feels it is time for someone else to take over.

XIV. Presentation of Business to Come Before the House

Doctor Perryman reminded the Delegates that only information in the handbooks will be considered at the reference committee meetings.

XV. Other Business

Doctor Perryman stated that tickets to the social functions are still available at the registration desk.

He stated that elections will be the first order of business when the House reconvenes Sunday.

The PLICO Forum will meet in the Wildcatter Room at 10:00 AM on Saturday, May 2. The Annual Shareholders Meeting for PLICO will be Sunday in the Closing Session. The Closing Session will meet at 9:00 AM Sunday, rather than 8:00 AM as originally scheduled. It will be held in the Plaza Room.

Doctor Perryman announced that the OSMA office is located adjacent to the registration desk.

The OSMA film *Preserving Tradition, Embracing Change* is being shown in the Auxiliary Hospitality Room. M. Joe Crosthwait, MD, made an announcement that the Oklahoma City Chamber of Commerce is selling sets of prints for \$1,500.00 to help defray expenses the Chamber incurred when it helped the Cowboy Hall of Fame during a time of financial crisis. The prints are on display by the OSMA registration desk.

Doctor Perryman announced that the AMA Delegates and Alternate Delegates will meet after lunch Saturday in Room 304.

XVI. Necrology Report

Doctor Perryman read the Necrology Report, after which a moment of silence was observed.

Doctor Perryman added Don Blair's name to the Report. (A copy of this Report is attached and made a part of these minutes.)

1986-87 Necrology Report

Donald J. Blair	Edward Leon Moore, MD
Odis A. Cook, MD	Iron Hawthorne Nelson, MD
Ralph Cameron Emmott, MD	Herbert L. Owen, MD
William Carl Ewell, MD	William W. Rucks, Jr., MD
William Pat Fite, Jr., MD	Welborn W. Sanger, MD
James Laurel Haddock, Jr., MD	Ralph A. Smith, MD
John D. Jennings, MD	John Robert Walter Spencer, MD
Phillip Wade Jones, MD	Marcella Steel Ruprecht, MD
Marianne Elsbeth Kosbab, MD	Fred D. Switzer, MD
Terry Dwight Leming, MD	Howard D. Tuttle, MD
Samuel Jackson McDaniel, MD	Edgar W. Young, Jr., MD
Eldon Clyde Mohler, MD	

XVII. Recess

The Opening Session of the House of Delegates was recessed at 4:05 PM.

Recorded by Ann McWatters and Susan Meeks.

Minutes

OSMA House of Delegates

CLOSING SESSION

Sunday, May 3, 1987, 9:00 AM

I. Call to Order and Introductions

The Closing Session of the 81st Annual Meeting of the House of Delegates was called to order by Speaker Larry L. Long, MD, Oklahoma City, at 9:10 AM in the Plaza South Room at the Sheraton Century Hotel, Oklahoma City, Oklahoma.

II. Invocation

Mrs. Kelsey Walters, outgoing Auxiliary President, led the invocation.

III. Introductions

Doctor Long then introduced several Past Presidents who were in attendance: Elvin M. Amen, MD; Ed L. Calhoon, MD; J. B. Eskridge III, MD; C. S. Lewis, Jr., MD; John A. McIntyre, MD; Floyd F. Miller, MD; and Orange M. Welborn, MD.

IV. Report of the Credentials Committee

Credentials Committee Chairman Roland A. Walters, MD, Oklahoma City, announced that a quorum was present.

V. Special Speakers

A. Doctor Long introduced Mrs. Jean Hill, Southern Regional Vice President of the AMA, for her remarks. Mrs. Hill noted that the Auxiliary shares concerns about changes in medicine, as well as how to turn these changes into advantages. She noted the Auxiliary is working: (1) to see that its members are informed and knowledgeable; (2) on action projects, specifically community health; and (3) for and with the medical profession to join them in their efforts. Mrs. Hill thanked the doctors for their support and cooperative efforts with the Oklahoma Auxiliary. She looks forward to continued cooperative efforts which will produce positive action and tangible results for all they seek to serve.

B. Doctor Long then introduced William H. Hotchkiss, MD, AMA President-Elect, for his remarks. Doctor Hotchkiss discussed the mandatory assignment dilemma and noted that Massachusetts has passed a law whereby doctors, in order to renew their medical license each year, must sign an agreement to accept assignment for all Medicare patients.

Doctor Hotchkiss noted it is inappropriate to discount fees for everyone over 65, as there are several individuals in this age bracket who can afford medical care. He explained that the Massachusetts law has been challenged in the court, and the AMA will follow it to the Supreme Court. The outcome of this law, he explained, will have its effect on other states, as some 10 or 11 different state legislative bodies are waiting on the final outcome of the Massachusetts law.

Doctor Hotchkiss explained that legislators respond to numbers, and the physicians represent only a small interest group compared with such groups as the AARP. However, Doctor Hotchkiss noted that the state of Wisconsin has come up with an idea and taken action by establishing liaison with senior citizen groups. The purpose of this liaison is to assess the income of Medicare beneficiaries and ask physicians to agree to accept assignment for those who qualify. He stressed that it is vital to establish such a program in order to avoid mandatory assignment. The AARP, he stated, is opposed to this idea because the group is demanding mandatory assignment. Doctor Hotchkiss urged the doctors to institute this program, which would make an extremely hard case for a legislator to then say that Oklahoma needs mandatory assignment.

VI. Remarks of the President-Elect

Doctor Long recognized Dr. M. Joe Crosthwait, President-Elect, for his remarks to the House. Doctor Crosthwait discussed the problems and frustrations physicians face today, pointing out that during a recent medical staff meeting the topic was not concerning better patient care, but rather on coping with the many obstacles to that care.

Doctor Crosthwait noted that through the years medical technology, science, and skills have improved tremendously, but today physicians are sued more often, and polls show the public continues to lose confidence in the profession.

Doctor Crosthwait stated his goal for the year is a reversal of the trend toward adversity between patients and doctors, and asked the doctors to commit themselves to making their patients their allies. He advised the physicians to bring their concerns and frustrations to their county society meetings, the state medical association, or the AMA, as these are the places to voice their frustrations, to become involved, and to work together for medicine's future.

[The complete text of Dr Crosthwait's remarks appears on page 461.]



VII. Annual PLICO Shareholders Meeting

Doctor Long declared the Annual Shareholders' Meeting of PLICO was in session, and introduced C. Alton Brown, MD, President of PLICO, to present a brief report. Doctor Brown explained the facets of PLICO's mission, which has been to keep premiums as low as possible commensurate with the financial security of the company, through (1) the availability of good reinsurance; (2) protecting the company's assets through quality investment; (3) making sure that the rates are adequate but not excessive; and (4) finding ways to cut costs and continue premiums.

Doctor Brown also reported that General Reinsurance paid to PLICO \$9 million to terminate its future liabilities with PLICO, a decision which was approved by the OSMA Board of Trustees. He also discussed the financial information included in the printed PLICO Report, which was made available to all physicians present.

Doctor Brown then discussed administrative changes made, including the retention of an in-house attorney to work as overseer of billings and premiums, as well as proposing the consolidation of the Underwriting Committee as a committee of the PLICO Board of Directors.

He then discussed PLICO Health, and stressed that this program offers a guarantee of insurability, stability, and a fair price. (A copy of the PLICO Report is made a part of the official minutes in the OSMA JOURNAL.)

Doctor Long then declared the PLICO Annual Shareholders Meeting closed.

VIII. Elections

Doctor Long explained that there are two contested races, and ballots have been prepared. AMA Alternate Delegate (Position III) has two nominees: Gary F. Strebel, Oklahoma City, and Arnold G. Nelson, MD, Midwest City. The other race is for the PLICO Board of Directors, as there are eight nominees for six positions: C. Alton Brown, MD, Oklahoma City; Kenneth W. Whittington, MD, Bethany; C. S. Lewis, Jr., MD, Tulsa; John A. McIntyre, MD, Enid; Edward K. Norfleet, MD, Vinita; Billy Dale Dotter, MD, Okeene; Robert A. Breedlove, MD, Stillwater; and Tim K. Smalley, MD, Stillwater.

Doctor Long called forward tellers Robert J. Weedn, MD, Duncan, Chairman; E. N. Scott Samara, MD, Oklahoma City; and Thomas J. Lowrey, Yukon, and appointed as associate tellers Dr. Donald R. Carter, Oklahoma City, and Dr. James B. Pitts, Jr. He then noted that once the tellers have tallied the vote, the winners would be announced.

Doctor Long then reviewed the following nominations for election:

Ray V. McIntyre, MD, Kingfisher, — *President-Elect*

John R. Alexander, MD, Tulsa — *Vice-President*

James D. Funnell, MD, Oklahoma City — *Secretary-Treasurer*

Ed L. Calhoon, MD, Beaver — *AMA Delegate (Position III)*

Victor L. Robards, Jr., MD, Tulsa — *AMA Delegate (Position V)*

Orange M. Welborn, MD, Ada — *AMA Delegate (Position VI)*

J. B. Eskridge III, MD, Oklahoma City — *AMA Delegate (Position VII)*

James B. Pitts, Jr., MD, Oklahoma City — *AMA Alternate Delegate (Position V)*

Michael J. Haugh, MD, Tulsa — *AMA Alternate Delegate (Position VI)*

George H. Kamp, MD, Tulsa — *AMA Alternate Delegate (Position VII)*

Trustee District VI: Oklahoma County

Trustee: Raymond L. Cornelison, Jr., MD, Midwest City

Alternate: Sara R. DePersio, MD, Oklahoma City

Trustee District XI: Atoka, Bryan, Choctaw, Coal, McCurtain & Pushmataha Counties

Trustee: No nominee

Alternate: Robert E. Engles, MD, Durant

Trustee District XII: Carter, Garvin, Johnston, Love, Marshall, Murray & Pontotoc Counties

Trustee: James V. Miller, MD, Ardmore

Alternate: Gary L. Paddock, MD, Ada

Trustee District XIII: Caddo, Comanche, Tillman, Cotton, Grady, Jefferson & Stephens Counties

Trustee: William S. Harrison, MD, Chickasha

Alternate: Robert J. Weedn, MD, Duncan

Trustee District XIV: Greer, Harmon, Jackson, Kiowa & Washita Counties

Trustee: No nominee

Alternate: Jeffry S. Lester, MD, Mangum

There being no objection from the floor of the House, Doctor Long declared the above slate of nominees duly elected, and congratulated the new officers and trustees. Doctor Long stated that individuals would later be appointed for those trustee positions for which there were no nominees.

IX. Reference Committee Reports

Doctor Long thanked the members of the House of Delegates who attended the Reference Committee meetings.

He then stated the Reference Committee Reports would be governed by Roberts Rules of Order. A Delegate can speak once for or against a question. Variation from that will be at the Chair's discretion. He asked that each Delegate state his name and county medical society when speaking before the House. Doctor Long stated that a recommendation by a Reference Committee is automatically introduced as a motion and does not require a second.

The Reference Committee Reports considered by the House are attached and made a part of the official minutes included in the July 1987 issue of the OSMA JOURNAL.

Report of Reference Committee I

Presented by Howard B. Keith, MD, Chairman

Reference Committee I approved the following items without amendment:

Item 1. Report of the Board of Trustees and the Supplemental Report of the Board of Trustees.

Item 2. Report of the Secretary-Treasurer and the Report of the Committee on Appropriations and Auditing.

Item 3. Report of the Council on Long-Range Planning and Development.

Item 4. Report of the Constitution and Bylaws Committee.

Item 5. Report of the Ad Hoc Committee on Young Physicians.

Item 6. Report of the Physicians Liability Insurance Company.

Item 7. Report of the Oklahoma State Medical Association Auxiliary.

Item 8. Report of the Oklahomans Against Lawsuit Abuse — Return to Reason Coalition.

Item 14. Report "A" of the Board of Trustees.

Item 15. Memorial Resolution — Donald J. Blair. The Reference Committee acknowledged that ordinarily memorial resolutions were not formally adopted; however, this resolution calls for the renaming of the OSMA Outstanding Layman Award to be known as the "Donald J. Blair Friend of Medicine Award."

Item 16. Commendation Resolution — OSMA JOURNAL.

Reference Committee I approved the following items as amended:

Item 13. Report "B" of the Board of Trustees. The Reference Committee recommended the following amendment to the last paragraph of Report "B," whereby an additional sentence would be added to read:

"The Underwriting Plan should be amended to require any physician wishing to appeal a decision to sign a waiver of rights to confidentiality."

During the discussion on the floor of the House, it was moved and seconded that this section of the Reference Committee's report be approved. A verbal vote was taken, and the Chair stated that the motion was passed. After further discussion, the decision on the motion was challenged by a hand vote of 53 to 45. A vote on the motion by show of hands was taken, with ayes 84 and nays 21, indicating the motion did indeed pass.

Reference Committee I referred the following items:

Item 9. Resolution 1 — AMA Delegates and Alternate Delegates. The Reference Committee recommended a referral, which, after further discussion and a motion passed on the floor of the House, was amended to read as follows:

"This resolution be referred to a special ad hoc committee of the OSMA Board of Trustees for study and ~~report back~~ submit a resolution to this House next year, and that the Oklahoma Delegation develop a resolution requesting the AMA to study this issue further."

Item 11. Resolution 9 — Perinatal Continuing Education. The Reference Committee recommended that this resolution be referred to the OSMA Perinatal Task Force for review and recommendation to the Board of Trustees.

Reference Committee I rejected the following items:

Item 10. Resolution 5 — AMA Delegates Terms. This resolution was withdrawn by the author, and the Reference Committee did not consider it.

Item 12. Late Resolution 14 — Malpractice Sales Commission Paid by PLICO. The Reference Committee received information to the effect that there would be a legal problem created for PLICO if this resolution were implemented.

Item 13. Late Resolution 16 — Board of Appeals. This item was considered in conjunction with Report "B" of the Board of Trustees, and the Reference Committee felt that underwriting responsibilities and appeals should be left to the PLICO Board of Directors.

The Report of Reference Committee I was then approved by the House as a whole, as amended.

Doctor Long then turned the meeting over to Robert G. Perryman, MD, Tulsa, Vice-Speaker.



Tellers Robert J. Weedn, MD, and E. N. Scott Samara, MD, collect ballots in the House of Delegates.

Elections

Doctor Perryman announced the election results: Gary F. Strelbel, MD, Oklahoma City, was elected to AMA Alternate Delegate Position III.

Those elected to the PLICO Board of Directors were: C. Alton Brown, MD, Oklahoma City; Kenneth W. Whittington, MD, Bethany; C. S. Lewis, Jr., MD, Tulsa; John A. McIntyre, MD, Enid; Billy Dale Dotter, MD, Okeene; and Tim K. Smalley, MD, Stillwater.

Report of Reference Committee II

Presented by John A. Blaschke, MD, Chairman

Reference Committee II approved the following items without amendment:

Item 1. Report of the President.

Item 2. Report of the Council on Professional and Public Relations.

Item 3. Report of the Council on Public and Mental Health.

Item 5. Report of the Council on Medical Services.

Item 6. Report of the Oklahoma State Medical Association Medical Students Section.

Item 8. Report of the JOURNAL of the Oklahoma State Medical Association.

Item 11. Resolution 4 — AMA Public Service Announcements.

Item 12. Resolution 6 — AMA Delegates Reports.

Item 15. Resolution 13 — Release of Patient Information.

Reference Committee II approved the following items as amended:

Item 4. Report of the Council on Medical Education. The Reference Committee wholeheartedly approved the Council Report and added three recommendations. During discussion and a motion passed on the floor of the House, Recommendation #2 was amended, to read as follows:

"Work closely with the University of Oklahoma College of Medicine officials to insure that there is a proper balance of ~~clinical~~ clinical faculty and practicing physicians represented on the OU College of Medicine's Board of Admissions . . ."

Item 7. Report of the Oklahoma Foundation for Peer Review. The Reference Committee had no written report from the Foundation to consider, and thus requested that the Foundation file a written report to the House each year.

Item 13. Resolution 11 — Creation of a Senior Citizens' Advisory Committee. The resolution was amended to read as follows, by adding an additional resolve on Line 14:

"throughout Oklahoma; and be it further

"Resolved, That county societies also be encouraged to initiate similar advisory committees."

Reference Committee II referred the following item:

Item 14. Late Resolution 12 — Public Relations Activities. The Reference Committee recommended that Late Resolution 12 not be adopted, but rather referred the matter, whereby the Council on Professional and Public Relations would be authorized to develop a comprehensive public relations plan with consultation from a professional public relations firm, that details of the plan with funding requirements be presented to the Board, and that specific recommendations be made to the House at its next annual meeting.

Reference Committee II rejected the following items:

Item 9. Resolution 2 — Annual Health Evaluations for Women. The Reference Committee recommended adoption of the following Substitute Resolution in lieu of Resolution 2:

"Resolved, That the OSMA go on record as favoring annual Papanicolaou (Pap) smears; and that this resolution be forwarded to the AMA; and be it further

"Resolved, That the OSMA seek an opinion from the AMA Council on Scientific Affairs as to the proper protocol for the examination of asymptomatic females over age 25."

Item 10. Resolution 3 — VIP Program. The Reference Committee recommended that the following Substitute Resolution be adopted, which was further amended in the House, in lieu of Resolution 3:

"Resolved, That the OSMA ~~study~~ study ~~implement~~ implement the VIP Program and ~~encourage~~ encourage assist in its implementation by all constituent societies of the Association."

Item 16. Late Resolution 15 — AIDS Education. The Reference Committee instead recommended that the following Substitute Resolution 15 be adopted:

"WHEREAS, The recent dramatic increase in patients with Acquired Immune Deficiency Syndrome is potentially the most serious threat to public health throughout the world; and

"WHEREAS, The prediction of the extent of spread of this fatal disease throughout our population by the end of this decade is unknown; now therefore be it

"Resolved, That the Oklahoma State Medical Association give support to education of the public in general, as well as to its own members concerning AIDS; and be it further

"Resolved, That the OSMA, through the Ad Hoc Committee on AIDS, help develop educational programs in conjunction with the Oklahoma State Department of Health for members and for the general public."

The Report of Reference Committee II was then approved by the House as a whole, as amended.

Report of Reference Committee III

Presented by William C. Stone, MD, Tulsa

Reference Committee III approved the following items without amendment:

Item 1. Report of the Council on Governmental Activities.

Item 2. Report of the Council on State Legislation.

Item 3. Report of the Council on Member Services.

Item 4. Report of the Oklahoma Medical Political Action Committee.

Item 6. Resolution 7—Waiver of Dues for Political Office Holders.

Reference Committee III approved the following item as amended:

Item 5. Report of the Physician Recovery Committee. The Reference Committee recommended that the report be amended on page 2, line 5, by adding the word *assistant* following the letters *PRC*, which more accurately addresses the OSMA Board of Trustees' action to create an assistant medical director for Eastern Oklahoma.

Reference Committee III referred the following item:

Item 7. Resolution 8—Opposition to Closing the College of Dentistry. The Reference Committee recommended adoption of the following Substitute Resolution 8, whereby each "WHEREAS, would remain the same, but with the following "Resolves" added, as noted below. During discussion and a motion passed on the floor of the House, the last sentence was also amended. The text is as follows:

"Resolved, That the College of Dentistry of the University of Oklahoma Health Sciences Center is an integral part of the health sciences of the State of Oklahoma and contributes significantly to the health care of the Oklahoma citizenry; and be it further

"Resolved, That the Oklahoma State Medical Association House of Delegates formally oppose the proposed plan to close the College of Dentistry as a cost-saving measure; and be it further

"Resolved, That a copy of this resolution be forwarded to the Office of the Governor of the State of Oklahoma, the President of the University of Oklahoma, the Provost of the University of Oklahoma Health Sciences Center, the Dean of the College of Dentistry, and the Oklahoma Dental Association, and that this communication be forwarded to the Board of Regents."

After considerable discussion on the floor of the House, it was moved, seconded, and carried that Substitute Resolution 8 be referred to the Board of Trustees. The Board could then postpone action on this resolution until sufficient information was received from the Dental Association and the Dental College.

The Report of Reference Committee III was then approved by the House as a whole, as amended.

Doctor Perryman expressed appreciation to all the members of the reference committees for their time and effort spent.

X. Other Business

Doctor Perryman announced that the prints for sale in the lobby are from the Cowboy Hall of Fame.

XI. Adjournment

There being no further business, the Closing Session of the 81st meeting of the House of Delegates adjourned at 11:40 AM.

Recorded by Toni Leverett and Debbie Hinson, Recording Secretaries

OSMA House of Delegates

RESOLUTIONS

MEMORIAL RESOLUTION

Donald J. Blair

(Approved)

Introduced by the OSMA Board of Trustees

WHEREAS, Donald J. Blair, Executive Director of the Oklahoma State Medical Association from 1962 to 1976, died on March 16, 1987; and

WHEREAS, His courage and leadership were first manifest as a U.S. Army Combat First Lieutenant and Battalion Forward Observer during the Korean conflict; and

WHEREAS, These qualities combined with absolute integrity, perception, and dedication enabled him to offer Oklahoma physicians a lifetime of unparalleled service; and

WHEREAS, The planning and construction of the OSMA Headquarters, the reorganization of the OSMA to a council/committee system, and the development of innovative professional liability insurance companies for physicians and hospitals are but a few of his many accomplishments that will live on as lasting memorials to his insight and expertise; and

WHEREAS, His impact on Oklahoma Medicine will long be remembered; now therefore be it

Resolved, That the members of the Oklahoma State Medical Association formally express their sorrow at his passing and extend their deepest sympathy to his wife and family; and be it further

Resolved, That the OSMA Outstanding Layman Award be henceforth known as the "Donald J. Blair Friend of Medicine Award," as an eternal reminder of the gratitude of Oklahoma physicians for his contributions to Oklahoma Medicine.

COMMENDATION RESOLUTION

OSMA JOURNAL

(Approved)

WHEREAS, The JOURNAL of the Oklahoma State Medical Association has been published since June, 1908; and

WHEREAS, The JOURNAL is the primary resource for the publication of scientific articles written by Oklahoma physicians; and

WHEREAS, The JOURNAL is the principal means by which OSMA communicates with its members; and

WHEREAS, The JOURNAL has recently been distinguished by the Sandoz Pharmaceutical Company as the Outstanding State Medical Journal in nationwide competition; now therefore be it

Resolved, That the House of Delegates hereby commend the Editorial Board: Editor-in-Chief, Mark R. Johnson, MD; Harris D. Riley, Jr., MD; and Donald L. Brawner, MD; and especially the Managing Editor, Ms. Susan Harrison, for their exemplary contribution to the JOURNAL and for bringing this distinguished award to the Oklahoma State Medical Association.



Claude B. Knight, MD, Wewoka, listens thoughtfully to the discussion of Reference Committee I.

RESOLUTION 1

(Referred)

Introduced by: Norman L. Dunitz, MD, President, OSMA
 Subject: **AMA Delegates and Alternate Delegates**
 Referred to: Reference Committee I

WHEREAS, It is vital that Oklahoma continues its aggressive and enthusiastic influence in the halls of the American Medical Association; and

WHEREAS, Our representatives to date have been so very capable and successful in representing our state association; and

WHEREAS, All members of our medical association are vitally interested in maintaining this level of representation and activity; now therefore be it

Resolved, That the following addendum be included in our rules for election and appointment of these Delegates to the American Medical Association:

I. Time of Election

Elections will be held at the annual meeting of OSMA, historically in the first part of May each year.

II. Qualifications of Office

A. Candidates must be members of the OSMA.

B. Candidates must be members of the OSMA House of Delegates.

C. Candidates must have served in the OSMA House of Delegates for five years prior to their candidacy.

III. Assumption of Office

Elected candidates will assume office ninety days after the election process and continue throughout their elected term.

IV. Terms of Office

A. The term of office for the Delegate position will be four years, i.e., two AMA terms.

1. Elections will be on a rotation basis, so that at this time two Delegates will be elected each year, except for the fourth year, in which only one will be elected.

B. Alternate Delegates will be elected for a term of two years.

1. These will be divided so that approximately half are elected each year.

V. Limitations of Term

A. Delegate positions will be limited to three successive elected four-year terms of office; in case of appointment to office, that term will not count against his elected limitations. This would therefore amount to a maximum total of 6 AMA terms, or 12 years.



Floyd F. Miller, MD, and Harl N. Stokes display the awards they received at the OU Alumni Dinner Friday night. Dr Miller was named Physician of the Year. Mr Stokes, executive vice-president of the Oklahoma Academy of Family Physicians, was honored with the Amicus Medicinae, or Friend of Medicine, award.

B. Alternate Delegates will be limited to three successive terms with the same considerations concerning an appointed term — a total of 6 years.

C. Miscellaneous

1. Removal from Office

a. Death

b. Voluntary retirement

c. If any Delegate misses three or more of the national AMA meetings, or in case of the Alternate Delegate, two of the national meetings, it will be the responsibility of the Executive Committee of OSMA to decide whether that Delegate may or may not continue in office.

2. In case of a vacancy for any reason, in any of the offices, the President of OSMA will appoint, with the approval of the Board of Trustees, an individual to fill out the remainder of that OSMA term.

VI. Exceptions to Limitations of Office

- A. Any Delegate who serves as a member of a national AMA leadership area, that is, an officer, member of the Board of Trustees, or member of a major council, shall not have that term of office, in which he is in such service, count against his limitations of membership on the OSMA Delegation. For clarification, if a member should serve even as little as one year in any capacity, the entire term of four years will be excluded from the limitation.

VII. Retired Physicians

- A. If a physician retires from active practice while serving as a member of the delegation he may continue to fill out his elected term.
- B. A physician who is retired from practice and is filling out his elected term, may stand for re-election at the House of Delegates meeting, with clear notification to the House that he is retired from active practice, but wishes to continue to represent OSMA.
- C. A physician who has retired from active practice cannot be a candidate for an initial term in office.

VIII. Election Process at the Annual OSMA House of Delegates Meeting

- A. Each candidate for each Delegate or Alternate Delegate shall be entitled to one nomination speech limited to three minutes only.
- B. Each candidate for each Delegate or Alternate Delegate position shall himself or herself speak in his/her own behalf for up to five minutes.
- C. The above will be done during the Opening Session of the meeting.
- D. The actual election will be by closed, printed ballots during the Closing Session of the meeting.

RESOLUTION 2

(Not Adopted)

Introduced by: OSMA Board of Trustees

Subject: **Annual Health Evaluations for Women**

Referred to: Reference Committee II

WHEREAS, The recommendations of the American Cancer Society concerning the frequency of Papanicolaou smears for sexually active women between the ages of 20 and 40 years have resulted in a furor of opposition from many physicians and scientific groups such as the American College of Obstetrics and Gynecology and the International Academy of Cytology; and

WHEREAS, Those recommendations may be fostering a dangerous attitude of each patient's total health as well as her gynecological health; and



JOURNAL Editor Donald L. Brawner, MD, Tulsa (right), presents a bound volume of the year's JOURNALS to retiring OSMA President Norman L. Dunitz, MD.

WHEREAS, Three years is too long a period of time for the unrecognized existence of many gynecological, cardiovascular, pulmonary, gastrointestinal, urological, neurological, psychiatric, endocrinological, hematological, immunological, dermatological, infectious (viral and bacterial), orthopedic and other diseases, both benign and malignant; and

WHEREAS, An annual health evaluation should neither be difficult nor expensive and thus cost-effective and in the best interest of quality health care of female patients; now therefore be it

Resolved, That the Oklahoma Division of the American Cancer Society recommends and urges the American Cancer Society to change its controversial Papanicolaou smear recommendations and to state that a major reason for such change is the Society's ability to respond positively to the overwhelming objections of physicians and other scientists and of many of the groups to which they belong; and be it further

Resolved, That the American Cancer society recommend annual health evaluations, including pelvic examinations and Papanicolaou smears, for all women and continue for life.

SUBSTITUTE RESOLUTION 2

(Not Adopted)

Resolved, That the OSMA go on record as favoring annual Papanicolaou (Pap) smears; and that this resolution be forwarded to the AMA; and be it further

Resolved, That the OSMA seek an opinion from the AMA Council on Scientific Affairs as to the proper protocol for the examination of asymptomatic females over age 25.

RESOLUTION 3

(Not Adopted)

Introduced by: Tulsa County Medical Society
Subject: **VIP Program**
Referred to: Reference Committee II

WHEREAS, The VIP Program was established by Tulsa County Medical Society to enable low income Medicare recipients to identify physicians who will accept "Medicare Assignment;" and

WHEREAS, The VIP Program has received statewide and national publicity; and

WHEREAS, Physicians from outside of Tulsa County have requested a similar program in which to participate; now therefore be it

Resolved, That the VIP Program become a statewide project of the Oklahoma State Medical Association.

SUBSTITUTE RESOLUTION 3

(Not Adopted)

Resolved, That the OSMA ~~study~~ implement the VIP Program and ~~encourage~~ assist in its implementation by all constituent societies of the Association.

RESOLUTION 4

(Adopted)

Introduced by: Tulsa County Medical Society
Subject: **AMA Public Service Announcements**
Referred to: Reference Committee II

WHEREAS, Oklahoma is a unified state which required physician members of county medical societies and Oklahoma State Medical Association to become members of the American Medical Association; and

WHEREAS, The American Medical Association, at the suggestion of Oklahoma State Medical Association, instituted a Public Awareness Campaign; and

WHEREAS, A significant part of a Public Awareness Campaign is the development of local media relations by county medical societies; and

WHEREAS, the American Medical Association produces quality Public Service Announcements which are important, visible ways in which health care messages are transmitted to the general public; now therefore be it

Resolved, That the American Medical Association provide upon request, to the county medical societies and state medical associations, in a timely way, the Public Service Announcements produced by American Medical Association, for distribution to and for use by local television stations, and that the Oklahoma State Medical Association adopt a like resolution to be introduced at the next session of the American Medical Association House of Delegates.



New OSMA Auxiliary President Julie Weedn, Duncan, and husband Robert enjoy the Inaugural festivities Saturday night.

RESOLUTION 5

(Withdrawn by Author)

Introduced by: Tulsa County Medical Society
Subject: **AMA Delegates Terms**
Referred to: Reference Committee I

WHEREAS, Delegates to the American Medical Association House of Delegates become active local leaders through participation in national debate concerning medical issues, and these Delegates are informed about AMA policies and services during their tenure and serve locally as valuable references; and

WHEREAS, The state medical association will be strengthened by increasing the number of participants in national policy determination, and competition for these positions will accentuate interest in state and national affairs; now therefore be it

Resolved, That the Oklahoma Delegates to the AMA House of Delegates be limited to three consecutive terms; however, Delegates elected or appointed to AMA councils or general officer positions would have that time excluded from any limitation; and be it further

Resolved, That the Oklahoma Delegation introduce the three consecutive term limitation resolution to the AMA House of Delegates during its 1987 interim meeting.

RESOLUTION 6

(Adopted)

Introduced by: Tulsa County Medical Society
Subject: **AMA Delegates Reports**
Referred to: Reference Committee II

WHEREAS, At both the Interim and Annual Meetings of the American Medical Association, actions are taken which will affect the future practice of medicine, and

WHEREAS, Every effort must be made to inform physicians of AMA actions; now therefore be it

Resolved, That the Delegates to the American Medical Association House of Delegates publish a brief summary of important actions taken by that body in the JOURNAL of the Oklahoma State Medical Association.

RESOLUTION 7

(Adopted)

Introduced by: Tulsa County Medical Society and
Oklahoma County Medical Society
Subject: **Waiver of OSMA Dues for Political Office Holders**
Referred to: Reference Committee III

WHEREAS, The Oklahoma State Medical Association recognizes the importance and urgency of physician involvement in the political process; and

WHEREAS, The Oklahoma State Medical Association believes that physician participation in the political process is an investment in the future of organized medicine; and

WHEREAS, The Oklahoma State Medical Association understands that a physician must make a financial sacrifice to hold elective office at the state and federal levels; and

WHEREAS, The Tulsa County and Oklahoma County Boards of Directors have approved resolutions to waive the annual membership dues of their respective societies for any member elected to Congress, the State Legislature, or the Executive Branch of the federal or state governments, and this policy will continue until the political term of such office expires; now therefore be it

Resolved, That the Oklahoma State Medical Association House of Delegates adopt a similar policy and that a like resolution be introduced at the next session of the American Medical Association House of Delegates.

RESOLUTION 8

(Not Adopted)

Introduced by: Oklahoma County Medical Society
Subject: **Opposition to Closing the College of Dentistry of the University of Oklahoma Health Sciences Center**
Referred to: Reference Committee III

WHEREAS, The College of Dentistry of the University of Oklahoma has established an outstanding record of accomplishment in the fifteen years it has existed on the campus of the Health Sciences Center, as follows:

- A) The College is fully accredited for a 10-year period;
- B) The faculty is distinguished in having written several textbooks which are used in dental schools throughout the world;
- C) Senior students in the past year scored in the top 20% nationally in the national board dental examinations;
- D) Dental hygiene graduates scored in the top 10% of the national boards; and

WHEREAS, The University of Oklahoma College of Dentistry is the only college of dentistry in Oklahoma, and the health of the entire state would decline to some degree by the act of closing the College for a possible reduction of the revenue deficit of the state; and

WHEREAS, There is at the present time a statistical deficiency in the number of dentists per one hundred thousand population in the state of Oklahoma as compared with the national average of 41 states; and

WHEREAS, Services to the low income families in the state of Oklahoma for dental care would be significantly reduced; and

WHEREAS, The ongoing effort of the University of Oklahoma and the Health Sciences Center to establish a record in EXCELLENCE of all aspects of its education, research and progress in the health care field would be significantly lessened by closing the dental school; and

WHEREAS, Nobody would disagree with the importance of reducing costs and perhaps reducing some programs during a retrenchment period consistent with the available budget, but it is a matter of plain thinking and common sense that the extreme measure of closing the school would be a destructive blow to the overall health care of Oklahoma; and

WHEREAS, Physicians in the Oklahoma County Medical Society and the Oklahoma State Medical Association depend on the College of Dentistry to provide practitioners of high quality dental care in their own communities; now therefore be it

Resolved, That the Oklahoma State Medical Association House of Delegates formally oppose the proposed plan to close the College of Dentistry as a cost-saving measure; and be it further

Resolved, That the President of the Oklahoma State Medical Association should issue a press release as soon as possible endorsing the work of the College of Dentistry and urging the Legislature to avoid the ultimate

catastrophe of closing the College, but continue to support it during these lean times until a better economic climate exists when the excellent work of the College of Dentistry can then be resumed; and be it further

Resolved, That a copy of this resolution be forwarded to the office of the Governor of the State of Oklahoma, the President of the University of Oklahoma, the Provost of the University of Oklahoma Health Sciences Center and the Dean of the College of Dentistry.

SUBSTITUTE RESOLUTION 8

(Not Adopted)

WHEREAS, The College of Dentistry of the University of Oklahoma has established an outstanding record of accomplishment in the fifteen years it has existed on the campus of the Health Sciences Center, as follows:

- A) The College is fully accredited for a 10-year period;
- B) The faculty is distinguished in having written several textbooks which are used in dental schools throughout the world;
- C) Senior students in the past year scored in the top 20% nationally in the national board dental examinations;
- D) Dental hygiene graduates scored in the top 10% of the national boards; and



Raymond L. Cornelison, Jr., MD, Midwest City, and OSMA Executive Director David Bickham begin the weekend with the OSMA Board of Trustees. Dr Cornelison, OSMA secretary-treasurer, chose not to run for re-election this year.

WHEREAS, The University of Oklahoma College of Dentistry is the only college of dentistry in Oklahoma, and the health of the entire state would decline to some degree by the act of closing the College for a possible reduction of the revenue deficit of the state; and

WHEREAS, There is at the present time a statistical deficiency in the number of dentists per one hundred thousand population in the state of Oklahoma as compared with the national average of 41 states; and

WHEREAS, Services to the low income families in the state of Oklahoma for dental care would be significantly reduced; and

WHEREAS, The ongoing effort of the University of Oklahoma and the Health Sciences Center to establish a record in **EXCELLENCE** of all aspects of its education, research and progress in the health care field would be significantly lessened by closing the dental school; and

WHEREAS, Nobody would disagree with the importance of reducing costs and perhaps reducing some programs during a retrenchment period consistent with the available budget, but it is a matter of plain thinking and common sense that the extreme measure of closing the school would be a destructive blow to the overall health care of Oklahoma; and

WHEREAS, Physicians in the Oklahoma County Medical Society and the Oklahoma State Medical Association depend on the College of Dentistry to provide practitioners of high quality dental care in their own communities; now therefore be it

Resolved, That the College of Dentistry of the University of Oklahoma Health Sciences Center is an integral part of the health sciences of the State of Oklahoma and contributes significantly to the health care of the Oklahoma citizenry; and be it further

Resolved, That the Oklahoma State Medical Association House of Delegates formally oppose the proposed plan to close the College of Dentistry as a cost-saving measure; and be it further

Resolved, That a copy of this resolution be forwarded to the Office of the Governor of the State of Oklahoma, the President of the University of Oklahoma, the Provost of the University of Oklahoma Health Sciences Center, the Dean of the College of Dentistry, and the Oklahoma Dental Association, and that this communication be forwarded to the Board of Regents.

RESOLUTION 9

(Referred)

Introduced by: Warren M. Crosby, MD
Subject: **Perinatal Continuing Education**
Referred to: Reference Committee I

WHEREAS, Perinatal continuing education is essential for each physician and hospital to maintain competency in the rapid and continuous advances in perinatal care; and

WHEREAS, Perinatal outcome can be influenced by improvements in perinatal care; and

WHEREAS, The perinatal health area is one fraught with a high level of liability risk; and

WHEREAS, PLICO spends an average of \$16,000 to defend each perinatal malpractice suit and an average of \$337,000 per loss; and

WHEREAS, PLICO loses 1 of 6 perinatal suits filed, compared with a 1 of 10 overall loss rate; and

WHEREAS, Improved perinatal care including risk identification and better recordkeeping has been demonstrated to reduce the risk of medicolegal liability; now therefore be it

Resolved, That the Oklahoma State Medical Association, as the major shareholder in the Physicians Liability Insurance Company (PLICO), direct the PLICO Board of Directors to require that each physician insured for obstetric and/or newborn care show evidence every five years that the insured has completed a course in perinatal continuing education that has been approved by the PLICO Board of Directors. Such educational effort would be repeated at five-year intervals to maintain insurability; and be it further

Resolved, That for the first five years PLICO will provide \$25,000 each year to support the development of acceptable programs.

RESOLUTION 11

(Adopted As Amended)

Introduced by: Council on Governmental Activities

Subject: **Creation of Senior Citizens' Advisory Committee**

Referred to: Reference Committee II

WHEREAS, The Oklahoma State Medical Association recognizes the need for open communication with senior citizens throughout Oklahoma; and

WHEREAS, The Oklahoma State Medical Association believes that increased communication between senior citizens and physicians is of the utmost importance to ensure the future quality of health care; and

WHEREAS, That same cooperation is necessary to ensure continued access for all concerned; now therefore be it

Resolved, that the Oklahoma State Medical Association hereby create a Senior Citizens' Advisory Committee to the Oklahoma State Medical Association to facilitate greater communication between the Association and senior citizens throughout Oklahoma; and be it further

Resolved, That county societies also be encouraged to initiate similar advisory committees.

(Late Resolution)

RESOLUTION 12

(Referred)

Introduced by: Council on Professional and Public Relations

Subject: **Public Relations Activities**

Referred to: Reference Committee II

WHEREAS, The Oklahoma State Medical Association has produced the documentary film *Preserving Tradition, Embracing Change*; and

WHEREAS, The film was shown on a statewide basis over OETA; and

WHEREAS, A scientific study of viewers of the film found they had significantly more positive perceptions of medicine and physicians, as the council expected; and

WHEREAS, It has become increasingly apparent that it will be necessary to purchase broadcast time and newspaper space in order for medicine to publicize its message; and

WHEREAS, The cost of purchasing such broadcast time and newspaper space exceeds the normal budget of the Council on Professional and Public Relations; now therefore be it

Resolved, That the OSMA agrees to assess each member \$40.00 per year to increase public relations activities.

RESOLUTION 13

(Adopted)

Introduced by: Council on Medical Services

Subject: **Release of Patient Information**

Referred to: Reference Committee II

WHEREAS, Many health insurance plans have provisions requiring the release of patient information to a third party; and

WHEREAS, Many patients don't understand that a blanket release of patient information permits a third party the right to review the entire medical record; and

WHEREAS, Professional ethics and state law dictate that the confidentiality of medical information is privileged; and

WHEREAS, Many times it is in the best interest of patient care to hold certain medical information in the strictest of confidence; now therefore be it

Resolved, That the Oklahoma State Medical Association advise its members that patient information requested by any third party, even with patient consent, be limited to only that information which is reasonably relevant to the particular medical or economic issue to be resolved.

(Late Resolution)

RESOLUTION 14

(Not Adopted)

Introduced by: Cleveland-McClain County Medical Society
Subject: **Malpractice Sales Commissions Paid by PLICO**

Referred to: Reference Committee I

WHEREAS, Physicians Liability Insurance Company is wholly owned by the membership of the Oklahoma State Medical Association; and

WHEREAS, There is virtually no marketing or sales activity performed by independent insurance agents; now therefore be it

Resolved, That the Oklahoma State Medical Association instruct Physicians Liability Insurance Company not to pay sales commissions on any malpractice insurance policy.

(Late Resolution)

RESOLUTION 15

(Not Adopted)

Introduced by: Cleveland-McClain County Medical Society
Subject: **AIDS Education**
Referred to: Reference Committee II

WHEREAS, The recent dramatic increase in patients with Auto Immune Deficiency Syndrome is the most serious threat to public health throughout the world to occur since the plague epidemics of the Dark Ages; and

WHEREAS, The prediction of the extent of spread of this fatal disease throughout our population by the end of this decade is staggering; now therefore be it

Resolved, That the Oklahoma State Medical Association shall actively support pending legislation in the Oklahoma State Legislature concerning AIDS; and be it further

Resolved, That the Oklahoma State Medical Association give support to education of the public in general, as well as to its own members concerning this terrible disease; and be it further

Resolved, That the OSMA have a training program for members and develop slide presentations to be shown to public groups throughout all communities in the state; and be it further

Resolved, That members will be mandated to report such cases to public health authorities if and when prescribed by law.

SUBSTITUTE RESOLUTION 15

(Not Adopted)

WHEREAS, The recent dramatic increase in patients with Acquired Immune Deficiency Syndrome is potentially the most serious threat to public health throughout the world; and

WHEREAS, The prediction of the extent of spread of this fatal disease throughout our population by the end of this decade is unknown; now therefore be it

Resolved, That the Oklahoma State Medical Association give support to education of the public in general, as well as to its own members concerning AIDS; and be it further

Resolved, That the OSMA, through the Ad Hoc Committee on AIDS, help develop educational programs in conjunction with the Oklahoma State Department of Health for members and for the general public.

(Late Resolution)

RESOLUTION 16

(Not Adopted)

Introduced by: Council on Member Services
Subject: **Board of Appeals**
Referred to: Reference Committee I

WHEREAS, The PLICO Underwriting Committee is a function of the OSMA Council on Member Services and is composed of OSMA physicians appointed by the President of OSMA; and

WHEREAS, The Underwriting Committee meets regularly to review the insurability of physicians eligible under the PLICO program, including new applicants, renewals, and to review those physicians with a significant loss experience on evidence of aberrant medical practice; and

WHEREAS, This underwriting process is a true peer review as conducted under the guidelines of the Underwriting Control Plan as approved by the OSMA and under the direction of the PLICO Board of Directors; and

WHEREAS, All underwriting recommendations must be reviewed and approved by the PLICO Board of Directors, and any appeals to these decisions are also heard by the PLICO Board of Directors; now therefore be it

Resolved, That the Underwriting Control Plan be amended to establish a new Board of Appeals composed of the OSMA President, the Chairman of the OSMA Board of Trustees, and three (3) members-at-large who shall be elected by the House of Delegates from its membership; and be it further

Resolved, That no appeals be heard without the appellant's signature to the "Waiver" of rights to confidentiality; and be it further

Resolved, That the "Waiver" become a part of the Underwriting Control Plan.

Reference Committee I

REPORTS TO THE HOUSE OF DELEGATES

Report of REFERENCE COMMITTEE I

Presented by: Howard B. Keith, MD, Chairman

Mr Speaker and Members of the House of Delegates:
Reference Committee I gave careful consideration to the several items referred to it and submits the following report:



Ed Kelsay, organizer of this year's Annual Meeting, sits down long enough to review the report of Reference Committee I.

(1) Report of the Board of Trustees and the Supplemental Report of the Board of Trustees

Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the Board of Trustees and the Supplemental Report of the Board of Trustees be filed for information.

Reference Committee I considered the Report of the Board of Trustees and the Supplemental Report of the Board of Trustees as one item. These reports are a brief review of actions taken by the Board during its meetings throughout the year. Your Reference Committee commends the Board for actions taken on behalf of the Association and would especially like to commend Dr Thomas N. Lynn, Jr., for his service as Chairman and Dr Rollie E. Rhodes, Jr., Vice-Chairman for 1986-87.

(2) Report of the Secretary-Treasurer and Report of the Committee on Appropriations and Auditing

Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the Secretary-Treasurer and the Budget and Audit Committee Report be adopted.

The Committee would like to express its sincere appreciation to Dr Raymond L. Cornelison, Jr., for his years of devoted service as Secretary-Treasurer of the Oklahoma State Medical Association.

(3) Report of the Council on Planning and Development

Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the Council on Planning and Development be filed.

(4) Report of the Constitution and Bylaws Committee.

Recommendation:

Mr Speaker, your Reference Committee recommends adoption of the Report of the Constitution and Bylaws Committee.

Mr. Speaker, your Reference Committee would like to remind the House of Delegates that the adoption of this report will create the Young Physicians Section of the OSMA as recommended by the AMA.

(5) *Report of the Ad Hoc Committee on Young Physicians Recommendation:*

Mr Speaker, your Reference Committee recommends adoption of the Report of the Ad Hoc Committee On Young Physicians.

Mr Speaker, your Reference Committee would like to acknowledge the honor of having Dr Robert C. Bowman and Dr Lee N. Newcomer selected to represent the Young Physicians Section as Delegate and Alternate Delegate respectively in the AMA House of Delegates.

(6) *Report of the Physicians Liability Insurance Company Recommendation:*

Mr Speaker, your Reference Committee recommends that the Report of the Physicians Liability Insurance Company be filed for information.

Mr Speaker, there is probably no single Association activity more important than the Physicians Liability Insurance Company. The Association owes a great deal of gratitude to the PLICO Board for the exemplary manner in which it has conducted the company's business. We congratulate them and encourage their continued vigilance.

(7) *Report of the Oklahoma State Medical Association Auxiliary Recommendation:*

Mr Speaker, your Reference Committee recommends that the Report of the OSMA Auxiliary be filed for information.

Mr Speaker, your Reference Committee would like to especially commend Mrs. Kelsey Walters, Auxiliary President, for her exceptional leadership and dedication.

(8) *Report of Oklahomans Against Lawsuit Abuse "Return to Reason" Coalition Recommendation:*

Mr Speaker, your Reference Committee recommends that the Report of Oklahomans Against Lawsuit Abuse be filed for information.

Mr Speaker, Your Reference Committee wishes to acknowledge the work of Mr. Don Blair on this project. He was a great friend of medicine and will be missed.

(9) *Resolution 1 — AMA Delegates and Alternate Delegates Recommendation:*

Mr Speaker, your Reference Committee recommends that this resolution be referred to a special ad hoc committee of the OSMA Board of Trustees for study and report back to this House next year.

Mr Speaker, your Reference Committee received a great deal of testimony regarding this resolution. Your committee is very sympathetic to the intention of this resolution. However, there are many technical difficulties involved in changing the method of election, length of terms, and number of terms for AMA Delegates and Alternate Delegates.



William S. Hotchkiss, MD, AMA president-elect and special guest at this year's Annual Meeting, fields questions at a Saturday press conference. Dr Hotchkiss was the keynote speaker at a joint luncheon of the OSMA and OSMA Auxiliary.

(10) *Resolution 5 — AMA Delegates Terms Recommendation:*

Mr Speaker, your Reference Committee was informed that Resolution 5 was withdrawn by the author.

(11) *Resolution 9 — Perinatal Continuing Education Recommendation:*

Mr Speaker, your Reference Committee recommends that this resolution be referred to the OSMA Perinatal Task Force for review and recommendation to the Board of Trustees.

(12) *Resolution 14 — Malpractice Sales Commission Paid by PLICO Recommendation:*

Mr Speaker, your Reference Committee recommends this resolution not be adopted.

Mr. Speaker, your Reference Committee received information to the effect that there would be a legal problem created for PLICO if this resolution were implemented.

(13) *Resolution 16 and Report "B" of the Board of Trustees Recommendation:*

Mr Speaker, your Reference Committee recommends that Resolution 16 not be adopted and that Report "B" of the Board of Trustees be adopted as amended.

Mr Speaker, your Reference Committee considered Resolution 16 and Report "B" of the Board of Trustees together since they both dealt with changes in the PLICO underwriting procedures. After carefully considering all of the testimony received, your committee recommends the following amendment to the last paragraph of Report "B": An additional sentence added to read, "The Underwriting Plan should be amended to require any physician wishing to appeal a decision to sign a waiver of rights to confidentiality." This last provision is designed to protect PLICO against a possible lawsuit for invasion of privacy in an appeal situation.

(14) Report "A" of the Board of Trustees

Recommendation:

Mr Speaker, your Reference Committee recommends that Report "A" of the Board of Trustees be adopted.

Mr Speaker, it is our understanding that the action of the House of Delegates last year was based on insufficient information and that there is already in progress a reduction in the Physicians' Assistant Program.

(15) Memorial Resolution — Donald J. Blair

Recommendation:

Mr Speaker, your Reference Committee wholeheartedly recommends approval of this resolution.

Mr Speaker, ordinarily memorial resolutions are not formally adopted, but usually filed for information purposes. However, this resolution calls for the renaming of the OSMA Outstanding Layman Award to be known as the "Donald J. Blair Friend of Medicine Award."

(16) Commendation Resolution — OSMA Journal

Recommendation:

Mr Speaker, your Reference Committee recommends the approval of this resolution.

Mr Speaker, Reference Committee I recommends adoption of this report as a whole as amended.

Mr Speaker, this concludes the report of Reference Committee I. Your Reference Committee wishes to thank all who participated in the hearing and contributed to the preparation of this report. As chairman of this Reference Committee, I would like to express my appreciation to the committee members and staff for their time and effort.

Respectfully submitted,
Howard B. Keith, MD, Shattuck, Chairman
Irwin H. Brown, MD, Oklahoma City
Frank K. Buster, MD, Cheyenne
Henry H. Modrak, MD, Tulsa
Bruce W. Walters, MD, Norman
John R. Alexander, MD, Tulsa
Ronald H. White, MD, Oklahoma City
Ed Kelsay, Staff
Debra Hinson, Staff



Report of the BOARD OF TRUSTEES

Subject: Annual Report

Presented by: Thomas N. Lynn, Jr., MD, Chairman

Referred to: Reference Committee I

Introduction

The Board of Trustees of the OSMA has completed three of its regular quarterly meetings for organizational year 1986-87. The fourth, or annual meeting, of the board is being held in conjunction with the 1987 annual meeting of the association in Oklahoma City. The proceedings of the annual board meeting will be contained in the Supplemental Report of the Board of Trustees.

During the past year, the board met in regular sessions on September 7 and November 16, 1986, and February 15, 1987. A quorum was certified for each meeting with an average of 8 officers, 17 trustees or alternate trustees, and 10 AMA delegates and alternate delegates present. In addition there were an average of 6 past presidents and 15 guests and OSMA staff members present at each meeting.

Council and Committee Reports

During each of its meetings the OSMA Board of Trustees hears reports from all of the association's councils and committees. During 1986-87 most of the association business brought before the board came through one of these groups. Since these groups also report directly to the House of Delegates on their year's activities, their reports to the board will not be reproduced here.

One council activity that was commended by the board does deserve separate attention here: During its September meeting the board took special note of the long years of leadership that Dr. William L. Hughes had exercised as Chairman of the association's Council on State Legislation. At that meeting a special plaque was commissioned, and on February 15 during the board's regular meeting, President Norman L. Dunitz, MD, presented the plaque to Doctor Hughes and expressed the association's gratitude for his long and distinguished service.

One other action by the board also deserves special note: During its September 7 meeting the Board of Trustees established a policy that smoking be restricted in all official OSMA council, committee, and board meetings.

PLICO, OFPR, and Auxiliary Reports

During each of its quarterly meetings the board heard reports from each of these three organizations: PLICO, OFPR, and the OSMA Auxiliary. Since each of these organizations also reports directly to the House of Delegates, they will not be reported separately here.



At his Inaugural, OSMA President M. Joe Crosthwait, MD, Midwest City, calls for unity.

Annual Meeting

Originally the 1987 annual meeting of the OSMA was scheduled to be held at Shangri-La Resort on Grand Lake. However, during its September 7 meeting the Board of Trustees voted to switch the 1987 and 1988 annual meeting locations so that this year's annual meeting would be held in Oklahoma City; at the same time, M. Joe Crosthwait, MD, would be installed as President of the OSMA. Traditionally the association has tried to hold its Tulsa and Oklahoma City meetings in years when physicians from those cities were being installed as president. However, several years ago there were two presidents in succession from outside either city, which threw the timing off from that point on. By making a correction this year, the Oklahoma City physician will be installed in Oklahoma City, the Tulsa president will be installed in Tulsa, and the president from out in the state will be installed at Shangri-La.

It was also pointed out that by going to a simpler meeting, i.e., eliminating the exhibits and most scientific programming, it might be possible for the association to hold its annual meeting in places other than just Oklahoma City, Tulsa, and Shangri-La.

Appeals

The Constitution and Bylaws of the OSMA provide that whenever a physician is dissatisfied with the outcome of a grievance hearing conducted by a county medical society, he/she has the right to appeal to the OSMA Board of Trustees. In addition, if the county society refuses to hear the grievance, or if the grievance involves more than one county society, any party to the grievance may appeal to the OSMA board.

It has long been the policy of the Board of Trustees, at the recommendation of the association's legal counsel, not to hear any appeal or grievance where there is litigation involved. During the past year two such appeals were brought to the association, and the board determined that it did not wish to waive its policy of not hearing appeals where litigation was involved.

Recommendation

It is the recommendation of the OSMA Board of Trustees that the House of Delegates reaffirm the long-standing policy that the association will not hear appeals of cases or situations that are in litigation or that become involved in litigation.

Cancer Society Recommendation

A resolution was formally adopted by the board during its September meeting that all OSMA members be encouraged to follow the American Cancer Society recommendations that PAP smears, pelvic examinations, and health evaluations be conducted on an annual basis for all women patients.

AMA Dues Increase

During its November 16 meeting the Board of Trustees instructed the association's delegates and alternate delegates to the American Medical Association to oppose an AMA dues increase for 1987-88.

911 Emergency Number

Also during its November meeting the Board of Trustees went on record as being in favor of the establishment of a statewide 911 emergency telephone number system.

AMA Young Physicians Section

During its September meeting, OSMA President Norman Dunitz announced to the Board of Trustees that he had named Drs. Lee Newcomer and Robert Bowman to represent the OSMA at the organizational meeting of the American Medical Association's Young Physicians Section, to be held in conjunction with the AMA's December mid-year meeting in Las Vegas.

During that meeting, in an almost unprecedented action, the Young Physicians section selected Drs. Bowman and Newcomer to serve as the delegate and alternate delegate to the AMA's House of Delegates.

Life Membership Awards

The following physicians have been awarded life membership in the Oklahoma State Medical Association through application from component societies, and with the approval of the association's Board of Trustees:

September 7, 1986

Dixon N. Burns, MD, Tulsa
Allen B. Eddington, MD, Tulsa
E. Edwin Fair, MD, Ponca City
John R. Hayes, MD, Shawnee

November 16, 1986

Jones B. Ballina, MD, Wellston
James P. Bell, MD, Oklahoma City
William R. Coutant, MD, Tulsa
Glenn P. Dewberry, Sr., MD, Oklahoma City
J. B. Eskridge III, MD, Oklahoma City
James M. Fite, MD, Ft. Gibson
Lillian M. Hoke, MD, Oklahoma City
Woodrow W. Massad, MD, Ponca City
Pamela Parrish, MD, Oklahoma City
Lindbergh J. Rahhal, MD, Oklahoma City
Harlan Thomas, MD, Tulsa
Ethel Walker, MD, Oklahoma City
Avery B. Wight, Enid
Clayton E. Woodard, MD, Tulsa

February 15, 1987

Robert G. Allen, MD, Bartlesville
Frank W. Clark, MD, Ardmore
John A. Graham, MD, Pauls Valley
Jake Jones, Jr., MD, Shawnee
Ruben H. Mayberry, MD, Ardmore
Richard W. Payne, MD, Oklahoma City
John E. Scott, MD, Bartlesville
Herbert B. Shields, Jr., MD, Enid
Milton J. Sugarman, MD, Elk City
Denton B. Thomas, MD, Tulsa
Robert I. Trent, MD, Oklahoma City

Respectfully submitted,
Thomas N. Lynn, Jr., MD, Chairman
OSMA Board of Trustees



Delegate Rebecca G. Tisdal, MD, Oklahoma City, a radiologist, takes her seat on the House floor.

Supplemental Report of the BOARD OF TRUSTEES

Subject: Supplemental Report

Presented by: Thomas N. Lynn, Jr., MD, Chairman
Referred to: Reference Committee I

Mr Speaker and Members of the House:

The Board of Trustees met at its Annual Meeting this morning, Friday, May 1, and this Supplemental Report reviews the actions taken by the Board at this meeting. This report will be referred to Reference Committee I to be considered along with the Annual Report of the Board of Trustees, which was included in the delegates handbook.

The Board meeting was called to order at 8:35 am by Thomas N. Lynn, Jr., MD, Chairman, who announced that a quorum was present. The invocation was led by Michael J. Haugh, MD, Tulsa. Doctor Lynn then introduced the guests in attendance.

The Board approved the minutes of the February 15 meeting as written.



In the House of Delegates, members consider a motion for referral.

Norman L. Dunitz, MD, addressed the Board as outgoing President. He noted a survey will be available during the Annual Meeting for the trustees to fill out concerning their preferences for a meeting format. He then expressed his appreciation in working with the association this past year, and commended the OSMA staff members for their fine work. Doctor Lynn expressed his appreciation on behalf of the Board for the efforts Doctor Dunitz has made to this organization.

Mrs Kelsey Walters, outgoing Auxiliary President, noted her appreciation for the opportunity of presenting Auxiliary activities to the Board during the past year. She then touched on the highly successful Medicine Day at the State Capitol on February 18, which she stated had quite an impact on the Representatives.

Mrs Walters then commented on the increased legislative efforts in the Auxiliary, and announced the formation of the new Jackson County Auxiliary. Mrs Walters expressed her pleasure in working with the Auxiliary's advisors and OSMA staff this year, and spoke of her appreciation for OSMA's involving the Auxiliary in its activities.

Dr Raymond L. Cornelison, Jr., Secretary-Treasurer, reviewed the financial audit, also reviewed by the Committee on Appropriations and Auditing, and noted that the committee concurs with his report, which will be made available to the House of Delegates.

Doctor Cornelison then reviewed the quarterly financial report, and the budget which was approved by the Board of Trustees at its February 15 meeting, and noted both of these items will also be considered by the House.

The Board then passed a motion to accept the Report of the Secretary-Treasurer and forward it on to the House of Delegates.

Doctor Cornelison expressed his enjoyment in working with the OSMA as Secretary-Treasurer, and commended the board members for their judiciousness in expenditure of association funds.

Mr Neal Thrift, Executive Director for the Oklahoma Foundation for Peer Review, presented his report and stressed that the OFPR's contract with HCFA emphasizes quality of medical care. Mr Thrift then commented that as a whole, people have become better educated as to OFPR's function and Medicare reimbursement. Also significant, Mr Thrift noted, is that in the past OFPR was running from 15 to 25 hospitals on intensified review, compared to one hospital now.

Mr Thrift then announced that OFPR will begin reviewing HMOs on June 1, and HMO doctors will be reviewing HMO claims. Mr Thrift said he would be glad to meet with hospital staffs and with any retirement groups around the state.

Dr M. Boyd Shook, President of the OFPR Board of Directors, stressed the emphasis on quality of care, and noted the cost for physician review is going up. He stressed the big thrust is in education. He also noted that sanctions are more colleague-to-colleague at this point, with an emphasis on education.

Mr David Bickham presented his Executive Director's report, which consisted of the following items primarily for the Board's information:

1) Return to Reason Coalition — Mr Bickham commented on the death of Don Blair, and the excellent job he performed while being Executive Director of the

coalition. Mr Bickham noted that many of the medical tort reform propositions were passed in the Legislature. He noted that the coalition as a whole, excluding OSMA, contributed almost \$90,000, compared with OSMA's total contribution of \$104,000, and commended the coalition on working with the OSMA. He also commended the State Chamber of Commerce in its instrumental work, and urged continued support of the Chamber, as well as the business community.

The Board then discussed the funds earmarked for tort reform activities, not totalling \$395,000. It was the consensus of the Board that funds be used specifically for tort reform in the years to come, as much more tort reform work lies ahead.

2) Letter from OSMA General Counsel, Dave Curlee — Mr Bickham explained Mr Curlee stated that OSMA would not be obligated to pay PLICO's debts in the event of PLICO's insolvency.

3) Letter from CIGNA — Mr Bickham noted INA merged with Connecticut General, and the letter concerns a trust fund. He noted a compromise may soon be reached where CIGNA and OSMA would divide the funds.

4) Letter from Baker & Hostetler — Mr Bickham urged the Board members to take this letter to their hospital legal counsel, as the letter summarizes a new federal law which will go into effect in 1988, to shield the medical peer review process from damage liability by imposing stringent reporting.

5) Letter from Credit Service, Inc. — Mr Bickham stated that OSMA uses an out-of-state collection agency, as thus far all other in-state agencies cannot operate statewide for OSMA. Mr Bickham noted from time to time he receives letters from local agencies, but could not use their services unless they possibly merge together to provide an umbrella service for the state.

6) Health Policy Agenda — Mr Bickham noted he has copies of the AMA HPA's Executive Summary for the trustees, and explained that this will be an excellent reference in the future.

Dr Larry L. Long, OMPAC Chairman, reviewed the financial and membership report included in the delegates handbooks, and thanked Mr David Bickham and Mr Robert Baker for their excellent help. Doctor Long then urged everyone to join OMPAC.

Mr Bickham then discussed Late Resolution 16, which proposes that a Board of Appeals be formed for underwriting purposes for the PLICO Board of Directors. Dr William O. Coleman, Chairman of the Council on Member Services which sponsors the resolution, commented on the Underwriting Control Plan and the Waiver. The Board passed a motion that Late Resolution 16 be forwarded to the House for consideration.

Dr M. Joe Crosthwait, Chairman of OSMA's Council on Professional and Public Relations, commented on Late Resolution 12, which calls for a \$40 assessment of the membership for public relations activities. Doctor Crosthwait noted the need for reinforcement in the public awareness program. He noted that much of the unused film footage from the OSMA's first presentation could be made into a second film for \$35-40,000. The Board passed a motion that Late Resolution 12 be forwarded to the House for consideration.

Doctor Coleman, Chairman of the OSMA Hospital Medical Staffs Section, announced he plans to run for office on the governing council of the AMA HMSS.

The Board then passed the motion to forward the following items to the House of Delegates: Return to Reason Coalition Report; a Memorial Resolution for Don Blair (late resolution); a Commendation Resolution for the OSMA JOURNAL (late resolution); Late Resolution 14 — "Malpractice Sales Commissions Paid by PLICO"; and Late Resolution 15 — "AIDS Education."

The Board reappointed Dr Donald L. Brawner, Tulsa, as an Editor of the OSMA JOURNAL.

The Board approved the following special memberships submitted for consideration at its annual meeting: Alfred T. Cox, MD, Undue Hardship; and for Life Membership, Donald D. Albers, MD; Kent Braden, MD; John M. Carey, MD; Sterling T. Crawford, MD; Curtis B. Cunningham, MD; Samuel E. Dakil, MD; Jess Hensley, MD; F. W. Hollingsworth, MD; Wolfgang Karl Huber, MD; Rex Kenyon, MD; Joseph N. Kramer, MD; David C. Lowry, MD; Haven Makin, MD; Lester I. Nienhuis, MD; J. R. Stacy, MD; and James S. Turner, MD.

Doctor Dunitz commended the following physicians who are retiring from the Board of Trustees: Thomas N. Lynn, Jr., MD; Rollie E. Rhodes, Jr., MD; Thomas E. Rhea, MD; and William Newland, MD.

The Board elected by acclamation Dr Jerry L. Puls, Tulsa, and Dr Lanny F. Trotter, Stillwater, as 1987-88 Chairman and Vice-Chairman of the Board of Trustees, respectively.

The Board approved the following nominees for the PLICO Board of Directors:

C. Alton Brown, MD, Oklahoma City
Kenneth W. Whittington, MD, Bethany
C. S. Lewis, Jr., MD, Tulsa
John A. McIntyre, MD, Enid
Edward K. Norfleet, MD, Vinita
Billy Dale Dotter, MD, Okeene
Robert A. Breedlove, MD, Stillwater
Tim K. Smalley, MD, Stillwater

The Board then elected Mr Lawrence W. Rember, Oklahoma City, former Director of the OU Alumni Association, as this year's recipient of the OSMA Outstanding Layman Award.

Mr Bickham then mentioned that the prints in the registration foyer are available for purchase from the Cowboy Hall of Fame.

There being no further business, the board adjourned at 11:00 am.

Respectfully submitted,
Thomas N. Lynn, Jr., MD
Chairman of the Board

Report A of the BOARD OF TRUSTEES

Subject: **Resolution No. 4 (A-86) as Amended**
Presented by: Thomas N. Lynn, Jr., MD, Chairman
OSMA Board of Trustees
Referred to: Reference Committee I

Introduction

The House of Delegates, while considering a resolution recommending a reduction in medical school admissions (No 4, A-86), amended the resolution to support suspension of admissions to the Physicians' Assistants Training Program at the University of Oklahoma Health Sciences Center:

"Resolved, That the OSMA recommend to the Oklahoma State Legislature and to the University of Oklahoma Health Sciences Center that an immediate suspension be placed on all admissions to the Physicians' Assistant Training Program; and be it further

"Resolved, That the OSMA recommend that the Oklahoma State Legislature introduce legislation repealing the Physicians' Assistant Training Act."

The Chairman of the Board of Trustees wrote a letter to the Dean of the Medical School advising of the House of Delegates action. Subsequently a meeting was convened with the Chairman of the Board, the President, the Dean, and the Executive Director.

Current Status of the Physicians' Assistant Program

The OUHSC PA Program was started in 1970; it was initially approved for 30 positions. By 1973 it reached its enrollment peak of 30 per year and is currently approved for 20 positions. Since inception the program has graduated 328 students, most of whom are in primary care situations, either in private practice or institutional settings. Of the 328 graduates, approximately 75% remain in Oklahoma.

Since 1983 the class size has been reduced to 20 students per year, and the current attitude of OUHSC officials is that 20 will continue to supply the demand for the foreseeable future.

In 1972 the Oklahoma Legislature passed an amendment to the Oklahoma Medical Practice Act that authorized the granting of a certificate to properly credentialed Physicians' Assistants who had an employment arrangement under the supervision of a physician acceptable to the Board of Medical Examiners. The BME has the legislative authority to grant and cancel certificates and to levy disciplinary measures against Physicians' Assistants. Physician members of the association and a member of the OSMA staff serve on the Physicians' Assistants Advisory Committee, which recommends certification, employment, and disciplinary activities of PAs.

The cost of the OUHSC PA Program is approximately \$219,000 per year, 65% of which is raised through grants and contracts including military contracts. The state's contribution to the program is less than \$70,000 per year.

Conclusion and Recommendation

It is the opinion of the Board of Trustees that the PA Program does not contribute materially to the oversupply of physicians, and that in fact graduates practice throughout Oklahoma in rural areas and in institutions and industry where physicians do not practice, and as extenders of medical care under physicians in private offices, public clinics, and hospitals. The board received many letters from physicians across the state in support of the Physicians' Assistants Program.

It is the recommendation of the Board of Trustees that the House rescind its action taken last year requesting a suspension of admissions to the program and repeal of the Physicians' Assistant Training Act by adoption of this Board Report.

Report B of the BOARD OF TRUSTEES

Subject: **PLICO Underwriting**
Presented by: Thomas N. Lynn, Jr., MD, Chairman
Referred to: Reference Committee I

Background

In 1977 OSMA changed its sponsored liability insurance program from the Insurance Company of North America (INA) to the Hartford Companies (Hartford). A portion of that agreement called for the development of a Loss Control Plan and an Underwriting Procedure. These plans (attached) were developed and presented to the House of Delegates for approval at the annual meeting in 1978. The Plan delegated the underwriting responsibility to the OSMA, on the assumption that physicians were more qualified to evaluate the relative risk of physician practices to the program. The association president was given the responsibility to appoint a physician chairman of the committee who would serve under the auspices of the Council on Member Services. The executive director was to serve as the risk manager. As a practical matter the function was assigned to the council, and the council chairman has served as the president's appointee. Various council chairmen have used different methods for accomplishing the underwriting task.

In 1980 the association started PLICO, and even though PLICO's Board was predominantly physicians, the underwriting function was left to the association.

As the experience of losses and claims grows, the underwriting responsibility becomes more significant. The underwriting plan requires the assessment of points for various aberrations which can result in insurance modification, cost, or even cancellation.

The Council on Member Services meets separately from the PLICO Board, and only one member of the board, Dr William Coleman, serves on the council (as chairman). Consequently, the PLICO Board is not privileged to all the information available to the committee, nor does the board have the advantage of the personal interviews often conducted by the council. This puts the PLICO Board in a difficult position, as its members are responsible for the final



Tulsans C. S. Lewis, Jr., MD, and Edward J. Tomsovic, MD, exchange views. Dr Tomsovic is dean of the University of Oklahoma Tulsa Medical College.

decision on the insurability of a colleague physician (which may lead to legal action) without actually participating in the deliberations that lead to the recommendation. The PLICO Board feels this is an untenable situation.

The OSMA Board of Trustees and House of Delegates have given the PLICO Board the final responsibility for determining the insurability of physicians by giving the appeals responsibility to the PLICO Board. To be consistent, the OSMA should also give to PLICO the responsibility for underwriting.

The PLICO Board has several committees: Investment, Claims, Risk Management, and Health. Should the House of Delegates agree to transfer underwriting, there would be another committee appointed for that purpose, and either five or seven members would be appointed from the PLICO Board who would meet before the bi-monthly PLICO Board meetings. In the event a particular underwriting case required special expertise, the committee would be authorized to use consultants just as other committees are now authorized.

The PLICO Board feels that by following the above procedure no expertise will be lost in the quality of underwriting, and the members of the committee will be advocates for the recommendation. Thus, the PLICO Board will then be more comfortable with the final decision.

Recommendation

It is recommended that the House of Delegates authorize the PLICO Board of Directors to amend the Underwriting Control Plan, transferring the underwriting responsibility to the PLICO Board of Directors.

The Underwriting Plan should be amended to require any physician wishing to appeal a decision to sign a waiver of rights to confidentiality.

UNDERWRITING CONTROL PLAN Oklahoma State Medical Association Professional Liability Program

I. GENERAL

- A. *Purpose:* As a function of the Risk Management/Loss Control service to be provided by the Oklahoma State Medical Association (Association) to the Physicians Liability Insurance Company (PLICO), this Underwriting Control Plan (Plan) will be followed by the Association's Underwriting Committee (Committee) in developing recommendations for PLICO's use in underwriting the professional liability insurance program.
- B. *Authority and Responsibility:* While the Committee's recommendations will normally receive favorable consideration, PLICO retains the final authority and responsibility for underwriting decisions.

II. ORGANIZATION AND FUNCTIONS

- A. *Underwriting Committee:* The Association President shall appoint an Underwriting Committee comprised of physician members of the Association and the Association's Executive Director, who shall be Risk Manager. A physician shall be designated by the Association President to serve as Chairman of the Committee. The committee shall serve under the direction and control of the Association's Council on Member Services. Liaison representatives from C. L. Frates and/or PLICO may be invited to attend Committee meetings.
- B. *Committee Charge:* The Underwriting Committee shall review the insurability of all physicians eligible for insurance under this program, such review to include all new applicants for coverage as well as a continuing review of all insured physicians. Underwriting recommendations to PLICO may include: (1) Coverage denial or cancellation; (2) Reduction of coverage limits to \$100,000/\$300,000; (3) Premium surcharge; and (4) Restricted coverage. Physicians who apply for or maintain insurance coverage must meet the following requirements: (1) Licensed in Oklahoma with predominant practice in the state; (2) Member in good standing of the Association, or a pending applicant for membership; (3) Nonmember who meets the Association's requirement as an Insurance Affiliate.
- C. *Meetings and Reports:* The Committee shall meet on call of the Chairman, but may function as necessary during interim periods via telephone conference calls. Reports of Committee activities shall be presented regularly to the PLICO Board of Directors. The report shall contain recommendations on individual underwriting problems.
- D. *Appeals:* A member of the Association or an Insurance Affiliate, may appeal an underwriting committee recommendation which denies or terminates insurance coverage, reduces coverage limits, requests practice restriction, or increases insurance cost through a premium surcharge.

The appeal must be made in writing to the PLICO Board of Directors within ten (10) days after being advised of the underwriting recommendation. The Board of Directors will hear and take action on the appeal within sixty (60) days after receiving written notice.

In the event no appeal is lodged, the recommendation of the Committee shall become effective immediately, or at a time set by the Committee. Such time must be at least twenty (20) days following the date of the Committee recommendation.

If an appeal is lodged, the appellant's insurance status shall remain unchanged until the day of the Board hearing. If the appellant physician does not appear for the meeting on that day, the decision of the PLICO Board of Directors becomes effective immediately. The Chairman of the Board may excuse an appellant physician for good cause shown, and the insurance status shall remain unchanged until the next hearing date established by the Board.

III. NEW APPLICANTS

- A. *Review:* All new applicants for Association-sponsored insurance shall be reviewed and approved by the Underwriting Committee, or by the Risk Manager acting within guidelines established by the Committee and approved by PLICO. The Risk Manager may approve coverage for a physician applicant under said guidelines, but may not disapprove coverage without the agreement of a majority of the Committee members.
- B. *Physicians Without Prior Practice Experience:* A physician without meaningful practice experience since completion of his professional education may be routinely approved for coverage by the Risk Manager absent any negative information knowledge; if negative information is known, a background investigation shall be conducted based on appropriate criteria as listed in C below.
- C. *Physicians With Prior Practice Experience:* A physician with prior practice experience since the completion of his education may be approved for insurance only after investigation by either the Underwriting Committee or the Risk Manager. If any of the following situations exist, the Committee will normally deny coverage; if coverage is to be afforded by special consideration, it may be provided only under conditions as described in Section VI of this Plan:
 1. Two or more significant reserved, paid or adjudicated liability claims during the past five (5) years which were based on demonstrated negligence, aberrant practice or practice beyond the physician's level of competence.
 2. Restriction, suspension, or revocation of hospital privileges for reasons related to professional competence.
 3. Surrender or loss of license to prescribe or dispense narcotics or loss of privilege to prescribe or dispense other scheduled drugs.
 4. Current or uncontrolled alcohol or drug abuse problems deemed by the Underwriting Committee to impair professional competence.

5. Criminal conviction involving a felony.
6. Falsification of application for insurance.
7. Any negative finding of a detrimental nature resulting from a background investigation including but not limited to contact with authorities in current or former practice locations, current or former hospital affiliations, current or former medical professional associations, or societies and current or former licensing boards.
- D. *Use of Binders:* Binders may be normally used to expedite coverage for new applicants who have not had prior practice experience since the completion of training and who are otherwise approved by the Risk Manager. Binders may not be issued if:
 1. Applicant is not a member of the Association, and is not willing to apply for membership or to become an Insurance Affiliate.
 2. Applicant has had prior practice experience and the underwriting investigation is incomplete.
 3. Applicant is a foreign medical graduate and the underwriting investigation is incomplete.

IV. RENEWALS

- A. *Periodic Re-application:* Physicians insured in 1980 will be required, prior to the beginning of 1982, to submit new applications. Thereafter, new applications for insurance will be required every third year. Each new application form will be compared to the previous form by C. L. Frates and Company to ascertain the correctness of rate classification.
- B. *Purpose of Re-application:* Because underwriting will be a continuous process, as presented in the next section of this Plan, the periodic re-application function will not normally involve any special activity other than re-assessing changes in practice as they affect rate classifications, or in adjusting the classifications of the insured population of physicians as may be required by new underwriting techniques. However, if a surcharge or termination decision is made by the Underwriting Committee within 60 days of the renewal date, the Committee may, at its discretion, defer the action to coincide with the insurance program's annual renewal date.

V. ONGOING CASE FINDING AND REVIEW

- A. *Case Finding:* The Underwriting Committee will establish liaison with the Oklahoma State Board of Medical Examiners, with other appropriate committees of the Association, with constituent county medical societies and with hospitals, for the purpose of interchanging information relevant to the competency of physicians. High-risk cases so identified will be investigated on a timely basis by the Committee and appropriate decisions will be made regarding the insurability of affected physicians.
- B. *Annual Loss Review:* Each year, PLICO and/or C. L. Frates and Company will furnish to the Underwriting Committee the particulars on all physicians having reserved claims or paid losses the last 5-year period. The Committee may request and receive additional information, including a personal interview with the physician during a called meeting. Based on its investigation and objective evaluation, the committee may recommend termination, the assessment of surcharges, reduced coverage limits, or restricted coverage.
- C. *Special Review:* The Underwriting Committee may also review individual physicians called to its attention by any other PLICO Committee, the management company, any committee or council of the Oklahoma State Medical Association, or by any county medical society, hospital administration or medical staff, or any other organization or individual having special knowledge that a particular physician might pose an extraordinary or unusual professional liability risk.
- D. *Review Investigation:* For underwriting purposes the Committee may request information from any source available to it. Additionally, the committee may request the physician to personally appear in order to discuss his practice situation directly and to answer all questions that the Council deems appropriate to the investigation.

VI. INDIVIDUAL RISK MODIFICATION PROGRAM

- A. *General:* All physicians who have applied for coverage or who are currently participating in the professional liability insurance program are subject to coverage denial or cancellation for cause, or they may be provided coverage by the Underwriting Committee under modified conditions and/or costs as described in this section.
- B. *Individual Risk Rating Procedure:* Measurements to identify high risk physicians are delineated below along with assigned negative points (or ranges of points):
 1. Demonstrated negligence, aberrant practice, or practice beyond the physician's level of competence. 10 to 50
 2. Restriction, suspension, or revocation of hospital privileges for reasons related to professional competence. 10 to 50
 3. Surrender or loss of license to prescribe or dispense narcotics or loss of privilege to prescribe or dispense other scheduled drugs. 20 to 50
 4. Health or age problem(s) which impairs professional competence. 0 to 20
 5. Current or uncontrolled alcohol or drug abuse problem deemed to affect professional competence. 10 to 50
 6. Failure of accused physician to cooperate with the Committee, PLICO, or with the defense counsel. 10 to 30

7. Failure to promptly report claims or potential claims in a manner which prejudices the defense of such claims. 10 to 30
8. Loss of medical license or felony conviction. 50
9. Disciplinary action or censure by Association or county medical society involving fee complaints, unethical practice, patient rapport problems or like circumstances which could generate liability claims. 0 to 20
10. Unusual or significant claim(s) history, including number of claims, amount of reserves necessary, or the amount of judgments or settlements. 10 to 50
- C. *Premium Surcharges or Cancellations:* The Committee, based on the cumulative negative point total assigned to a physician, is required to recommend cancellation or denial of insurance if a physician has a cumulative point total of 50 points. If the points assessed range from 10 to 40, the Committee may recommend that premium surcharges be invoked either singularly or in combination with other penalties (see Paragraph D), as follows:

Total Points	Premium Surcharge	Minimum Surcharge
1. 10 points	25%	\$ 500
2. 20 points	50%	1,000
3. 30 points	100%	2,000
4. 40 points	200%	4,000

- D. *Alternative Risk Modifiers:* In order to achieve optimum underwriting effectiveness, the Committee may recommend the following alternatives, singularly, in combination with each other, or in combination with premium surcharges as deemed necessary under variable circumstances:
 1. The physician's written agreement to accept specified practice limitations.
 2. Reduce physician's coverage limits to \$100,000/\$300,000.
- E. *Terms of Surcharges:* The foregoing premium surcharges will normally apply for a three-year period. The surcharge shall become effective upon 10 days notice and the first period of the 3-year penalty shall end on the last day of the year imposed (even though less than one full year).

A premium surcharge may be modified by the Committee at the beginning of the second or third years, within the following ranges:

1. Second 12 months: 50% to 100%
2. Third 12 months: 0% to 100%

Report of the SECRETARY-TREASURER

Subject: Annual Report

Presented by: Raymond L. Cornelison, Jr., MD
Secretary-Treasurer

Referred to: Reference Committee I

Introduction

There are three parts to the Secretary-Treasurer's Report:

1. The consolidated 1986 year end audit prepared by Price-Waterhouse (on yellow paper). Remember the audit report integrates the PLICO's operations into the OSMA's financial statement since we own all the stock. For more information on PLICO refer to the financial statement in the handbook;
2. The quarterly statement (on ivory paper) covering OSMA's operations through March 31, 1987; and
3. The proposed budget for 1987 (on green paper) which was adopted by the Board of Trustees at its February meeting.

In general the OSMA is in good financial condition. Even though we have not had a dues increase for the past five years, we have ended three of those years with modest operating surpluses, and the two years we had deficits were the result of special projects that were non-recurring, and we had sufficient reserves to cover our losses.



Judy Crosthwait watches proudly as her husband assumes the OSMA presidency.

The Year End Audit (yellow paper)

In the asset section (first page, consolidated balance sheet), assets are up by about \$1.5 million, which reflect the assessment made in 1986 for tort reform and PLICO. In the property and equipment section we have revalued downward some of our furniture and equipment, and the increase in our equity in PLICO of about \$1 million is, again, the result of the assessment.

The bottom line is that assets are about \$1.5 million greater in 1986 than in 1985.

The liabilities section, page two, reflects the assessment money payable to PLICO and the increase in our equity.

On the third page is a summary of revenue and expenses. Please note that before adjustments, revenue exceeded expenses by almost \$1.9 million, and after adjustments including PLICO's \$600,000 loss (which we understand is a paper loss), we still ended the year with a surplus of \$1.5 million, which is about equal to the assessment. Remember that the majority of these funds will be transferred to increase the surplus of PLICO.

Page 4-10 are a more detailed explanation of what I have already explained. Page 10 is a summary of PLICO's operations, and you will note that PLICO booked losses of about \$200,000 in 1985 and almost \$600,000 in 1986. But you should note, at the top of the page, that PLICO's assets went up almost \$5.5 million during that same period. Since PLICO pays no dividends, it is to our advantage to recognize losses at the most conservative level to avoid taxes. Incurred but not reported losses are booked at the maximum allowable, hence the losses as shown in the statement.

Pages 11-13 are detailed breakdowns of revenue and expenses.

Last year the officers pledged an attempt to effectuate a savings of 5% or to enhance revenue such that the combination would result in a positive cash flow for the association. If you'll look on page 12 and compare expenses, you will note that in some areas we were able to save; other expenses were higher than 1985, but in many of these cases the actual expenditures were less than budgeted amounts. Such was the case with the Physicians Recovery Program, and out-of-state travel and in-state travel. Other expenses of an unusual nature such as the disposition of the computer and depreciation and amortization are accounting expenses and not cash outlays.

Taking everything into consideration, the association has accomplished the savings promised, and each member's share in the ownership of OSMA has gone up in value since 1985.

March 31 Quarterly Statement (ivory paper)

The quarterly statement summarizes the revenue and expenses for the first three months of the year. There is really nothing dramatic to report. Assets and liabilities are consistent with the year-end report, and revenues exceed expenses by \$52,000, which is normal for the time of year. Expenses are about as projected.

Proposed Budget for 1987 (green paper)

The budget for 1987 projects revenue of \$1.2 million and expenses at about \$1 million. There are no major changes in program expense. We have realigned some expenses for accounting purposes; the auxiliary expense is listed with other program and council expense, the Young Physicians Section is budgeted for the first time, and some public relations expense has been moved to the council rather than the general membership expenses. With only a few exceptions the proposed budget for 1987 is an extension of 1986 programs.

Summary and Conclusions

OSMA's financial condition at year end 1986 is good. We have a modest reserve, and revenues have again exceeded expenses. The officers and staff should be commended for holding the line on expenditures. The budget for 1987 is reasonable and continues all of the programs from 1986 and provides for funding a new Young Physicians Section, as well as an expansion of the Physicians Recovery Program.

Delegates should be aware that almost one-half of OSMA's income is derived from non-dues. Should these sources of revenue become not available to OSMA, then the delegates will be faced with increasing dues. Likewise any major expenditures or increases in program expenses will require additional funding.

Respectfully submitted,
Raymond L. Cornelison, Jr., MD
Secretary-Treasurer

**THE COMMITTEE ON APPROPRIATIONS AND AUDIT
CONCURS IN THIS REPORT.**

Oklahoma State Medical Association and Subsidiary
Consolidated Balance Sheet

Assets	December 31,	
	1986	1985
Current assets		
Cash	\$ 935,173	\$ 1,559
Savings accounts and certificates of deposit	269,499	474,692
Accounts receivable	1,009,501	644,301
Inventory	882	17,233
Prepaid expenses	6,725	11,090
Total current assets	2,221,780	1,148,875
Property and equipment:		
Land	7,808	7,808
Building	384,998	383,093
Pavement	—	2,451
Furniture, fixtures and equipment	128,908	448,834
Equipment under capital lease	15,330	15,330
	537,044	857,516
Less — Accumulated depreciation	(77,254)	(228,446)
	459,790	629,070
Equity in unconsolidated subsidiary	4,054,197	3,399,435
Other assets:		
Due from reinsurance companies	370,000	370,000
Loan acquisition costs, net of amortization	3,403	3,843
	373,403	373,843
	\$7,109,170	\$5,551,223

The accompanying notes are an integral part of this statement.

Oklahoma State Medical Association and Subsidiary
Consolidated Balance Sheet

Liabilities and Fund Balances	December 31,	
	1986	1985
Current liabilities:		
Current portion of long-term debt	\$ 8,132	\$ 7,075
Accounts payable	847,753	443,797
Accrued pension costs	—	1,900
Deferred income	659,685	656,185
Total current liabilities	1,515,570	1,108,957
Long-term debt	127,003	135,134
Commitments	—	—
Fund balances:		
Unappropriated	5,466,597	4,307,132
	\$7,109,170	\$5,551,223

The accompanying notes are an integral part of this statement.



Saturday's Derby Day Party drew a crowd of fun-seekers and racing enthusiasts.

Oklahoma State Medical Association and Subsidiary
Consolidated Statement of Revenues and Expenses

	Years ended December 31,	
	1986	1985
From operations:		
Revenue	\$2,852,440	\$ 886,617
Expenses	976,660	867,099
Excess of revenue over expenses from operations	1,875,780	19,518
JOURNAL:		
Revenue	105,384	109,908
Expenses	176,251	163,062
Excess of expenses over revenue from JOURNAL	(70,867)	(53,154)
Annual meeting:		
Revenue	40,508	42,480
Expenses	90,718	92,507
Excess of expenses over revenue from annual meeting	(50,210)	(50,027)
Excess (deficit) of revenues over expenses before other revenue (expenses)	1,754,703	(83,663)
Other revenue (expenses):		
Loss from unconsolidated subsidiary	(595,238)	(196,734)
Excess (deficit) of revenues over expenses	\$1,159,465	\$(280,397)

The accompanying notes are an integral part of this statement.

Oklahoma State Medical Association and Subsidiary
Consolidated Statement of Changes in Unappropriated Fund Balance

	Years ended December 31,	
	1986	1985
Balance, beginning	\$4,307,132	\$4,521,693
Transfers from appropriated funds:		
Public Education	—	35,619
Building Maintenance	—	30,217
Excess (deficit) of revenues over expenses	1,159,465	(280,397)
Balance, ending	\$5,466,597	\$4,307,132

The accompanying notes are an integral part of this statement.

**Oklahoma State Medical Association and Subsidiary
Consolidated Statement of Changes in Financial Position**

	Years ended December 31,	
	1986	1985
Working capital provided:		
From operations:		
Excess (deficit) of revenues over expenses	\$1,159,465	\$(280,397)
Expenses not affecting working capital during the current period —		
Equity in loss of subsidiary	595,238	196,734
Depreciation and amortization	74,370	67,644
Total from (for) operations	1,829,073	(16,019)
Book value of assets sold or retired	137,763	—
Decrease in due from Federal Deposit Insurance Corporation	—	72,196
Total working capital provided	1,966,836	56,177
Working capital used:		
Purchase of property and equipment	42,413	33,057
Investment in subsidiary	1,250,000	500,000
Decrease in long-term debt	8,131	6,878
Total working capital used	1,300,544	539,935
Increase (decrease) in working capital	\$ 666,292	\$(483,758)

Changes in Components of Working Capital

Increase (decrease) in current assets:		
Cash	\$ 933,614	\$ (7,795)
Savings accounts and certificates of deposit	(205,193)	(478,876)
Accounts receivable	365,200	(432)
Inventory	(16,351)	17,233
Prepaid expenses	(4,365)	6,057
	1,072,905	(463,813)
(Increase) decrease in current liabilities:		
Current portion of long-term debt	(1,057)	(870)
Accounts payable	(403,956)	(4,540)
Accrued pension costs	1,900	100
Deferred income	(3,500)	(14,635)
	(406,613)	(19,945)
Increase (decrease) in working capital	\$ 666,292	\$(483,758)

The accompanying notes are an integral part of this statement.

**Oklahoma State Medical Association and Subsidiary
Notes to Consolidated Financial Statements**

Note 1 — Significant Accounting Policies:

The following is a summary of certain significant accounting policies followed in the preparation of these financial statements. Except for the omission of depreciation on the building, these policies conform to generally accepted accounting principles:

Basis of presentation: The consolidated financial statements include the accounts of Oklahoma State Medical Association and its wholly-owned subsidiary, OSMA Member Services Corporation. The subsidiary was incorporated February, 1986 for the purpose of carrying on certain profitable activities not consistent with the non-taxable status of the Association. All intercompany accounts and transactions have been eliminated in the consolidated statements.

Property and equipment: Property and equipment, including the capitalized leases, are recorded at cost. Depreciation of the property, except the building, is computed using the straight-line method over estimated useful lives ranging from 3 to 10 years.

Investment in unconsolidated subsidiary: Investment in Physicians Liability Insurance Company (a wholly-owned subsidiary) is accounted for by the equity method. Under this method the Association's equity in the net earnings or losses of the subsidiary is included currently on the Association's statement of revenues and expenses. Any dividends received from the subsidiary will be reflected as a reduction of the investment.

Loan acquisition costs: Loan acquisition costs are amortized on a straight-line basis over the life of the loan.

Income taxes: The Association was organized as a nonprofit organization and, as such, is exempt from income taxes under Section 501(c)(6) of the Internal Revenue Code.

Note 3 — Due From Reinsurance Companies:

In 1984, the Association reached a settlement with Hartford Insurance Company ("Hartford") and Lloyd's of London ("Lloyd's") regarding certain coverage the insurance companies had provided for insured doctors in the State of Oklahoma during 1977. As part of the agreement, certain funds that had been held in trust securing potential claims were released to the Association.

Included in the settlement was a claim by the Association against Hartford and Lloyd's totaling \$370,000 representing refunds due on excess premiums paid to the companies. While the Association still considers this a valid and collectible receivable, due to the uncertainty as to when payment will be received, the amount is classified as noncurrent for financial purposes.

Note 4 — Accounts Payable:

The following is a summary of the accounts payable at December 31, 1986 and 1985:

	1986	1985
Trade	\$ 51,009	\$ 66,309
Physicians Liability Insurance Company	752,500	152,500
Dues	30,490	9,602
Leebron memorial Fund	7,040	7,132
Medical education endowment	—	202,631
Other	6,714	5,623
	<u>\$847,753</u>	<u>\$443,797</u>

Note 5 — Long-Term Debt:

The following is a summary of long-term debt at December 31, 1986 and 1985:

	1986	1985
Note payable to a company; secured by real estate; payable in 180 monthly payments of \$1,448 including interest at 10% and one payment of \$69,548 due in 1994	\$125,303	\$129,892
Capitalized lease; secured by certain equipment; payable in monthly payments of \$385 including interest at 19%	9,832	12,317
	135,135	142,209
Less — Current portion	(8,132)	(7,075)
	<u>\$127,003</u>	<u>\$135,134</u>

The scheduled maturities of the long-term debt are as follows:

1988	\$ 9,375
1989	9,179
1990	6,834
1991	7,550
1992	8,340
1993-1994 (Term)	85,725
	<u>\$127,003</u>

Note 6 — Retirement Plan:

The Association has a defined benefit pension plan which covers employees who are twenty-one years of age or older and have at least six months of service. The plan has a fiscal year of June 1 to May 31. The total pension expense for 1986 and 1985 was \$27,099 and \$25,509, respectively. The amount of accrued pension expense for the year is funded by the Association in annual contributions to the pension plan. The actuarial present value of the accumulated benefits to participants of the plan and the net assets available for those benefits as of the beginning of the plan years 1986 and 1985 as follows:

	1986	1985
Actuarial present value of the accumulated plan benefits:		
Vested	\$ 59,874	\$ 80,928
Nonvested	6,651	5,326
	<u>\$ 66,525</u>	<u>\$ 86,254</u>
Net assets available for benefits	<u>\$216,811</u>	<u>\$166,003</u>

In determining the actuarial present value of the accumulated plan benefits, an assumed weighted average rate of 7-8% was used.

SECRETARY-TREASURER

Note 7 — Deferred Income:

The following is a summary of deferred income at December 31, 1986 and 1985:

	1986	1985
Dues	\$659,685	\$649,040
Director advertising	—	7,145
	<u>\$659,685</u>	<u>\$656,185</u>

Note 8 — Commitments:

In February, 1986, the Board of Trustees voted to assess all members a fee that was to fund a capital contribution to Physicians Liability Insurance Company (PLICO) and to provide support for proposed tort reform legislation. The total assessment was approximately \$1,900,000 of which approximately \$1,400,000 was to be paid to PLICO as of December 31, 1986, \$1,250,000 of these funds have been allocated to PLICO.

In addition, the Association is committed on certain automobile leases in future years as follows:

1987	\$12,370
1988	6,820

Note 9 — Related Party Transactions:

For the years ended December 31, 1986 and 1985, the Association had an agreement with Physicians Liability Insurance Company, a wholly-owned unconsolidated subsidiary, to provide certain services for the insurance company. The Association incurred expenses totaling \$182,862 and \$46,728 for 1986 and 1985, respectively, and was reimbursed a total of \$325,000 and \$125,000 for 1986 and 1985, respectively, by the subsidiary.

Note 10 — Professional Liability Stabilization Program:

The Professional Liability Stabilization Program was established during the year ended May 31, 1976 by assessing the doctors a 15% surcharge on their basic professional liability policies. The Insurance Company of North America provided the basic \$100,000/\$300,000 policy. This money is under the control of two trustees, one appointed by the Association and one appointed by the insurer. As of December 31, 1986 the balance on deposit was \$564,333, which is not included in the financial statements. The funds will be used only if the insurer's reserves are exhausted through payment of claims.

Note 11 — Equity in Unconsolidated Subsidiary:

The following is a condensed balance sheet and statement of operations for the unconsolidated subsidiary:

	December 31,	
	1986	1985
Assets:		
Investments	\$33,091,941	\$29,199,402
Other	2,779,563	1,265,303
	<u>\$35,871,504</u>	<u>\$30,464,705</u>
	December 31,	
	1986	1985
Liabilities and Stockholders' Equity:		
Unearned premiums	\$ 2,501,563	\$ 2,127,851
Losses and loss adjustment expense	27,611,865	23,214,324
Other	1,703,879	1,723,095
Total stockholders' equity	4,054,197	3,399,435
	<u>\$35,871,504</u>	<u>\$30,464,705</u>
Revenue:		
Premiums earned	\$25,239,797	\$20,533,436
Investment income and fees	4,389,128	3,384,289
	<u>29,628,925</u>	<u>23,917,725</u>
Expenses:		
Losses	19,591,031	16,664,648
Loss adjustment	5,985,423	3,786,526
Other operations	4,647,709	3,663,285
	<u>30,224,163</u>	<u>24,114,459</u>
Net loss	<u>\$ (595,238)</u>	<u>\$ (196,734)</u>

The subsidiary is not consolidated due to the diversity of operations and lack of management control by the parent.

Oklahoma State Medical Association and Subsidiary Consolidated Schedule of Revenues

	Years ended December 31,	
	1986	1985
From operations:		
Membership dues	\$637,592	\$612,907
Special assessment	1,896,424	—
Interest and other	139,502	102,949
Building lease	28,800	29,400
Membership directory	27,059	5,166
Computer	123,063	\$136,195
Total revenue from operations	<u>\$2,852,440</u>	<u>\$886,617</u>
From JOURNAL:		
Subscriptions allocated from dues	\$ 31,431	\$ 31,346
Advertising and sales	73,953	78,562
Total revenue from JOURNAL	<u>\$105,384</u>	<u>\$109,908</u>
From annual meeting:		
Exhibit fees	\$ 28,421	\$ 26,130
Contributions	300	800
Ticket sales	11,878	14,515
Short courses	—	1,035
Total revenue from annual meeting	<u>\$ 40,508</u>	<u>\$ 42,480</u>

Oklahoma State Medical Association and Subsidiary Consolidated Schedule of Expenses

	Years ended December 31,	
	1986	1985
General membership expenses:		
Salaries	\$ 321,499	\$ 324,503
Awards	10,689	2,173
Councils	87,293	108,837
Data processing	28,982	26,864
Depreciation and amortization	74,426	67,644
Dues and subscriptions	5,055	2,917
Equipment rental and expense	32,427	32,350
In-state travel	2,340	1,613
Insurance	55,850	40,916
Interest	14,917	14,536
Legal and professional	15,010	12,032
Loss prevention project	49,968	46,728
Membership directory	18,471	1,554
Office supplies	23,898	25,502
OSMA newsletter	11,100	8,909
Out-of-state travel and AMA convention	70,776	73,696
Payroll taxes	24,219	23,995
Pension costs	27,099	25,509
Physicians recovery program	49,437	26,066
Postage and shipping	40,241	31,510
Repairs and maintenance	9,132	7,686
Services	6,035	3,621
Special projects	168,059	53,289
Staff and officers	36,761	47,008
Telephone and utilities	43,685	44,614
Loss on disposition of computer equipment	137,711	—
Other general expense	10,022	6,330
Total before allocation of overhead	<u>1,375,102</u>	<u>1,060,402</u>
Expense reimbursement from subsidiary	(325,000)	(125,000)
Overhead allocated to JOURNAL	(39,805)	(34,974)
Overhead allocated to annual meeting	(33,637)	(33,329)
Total general membership expenses	<u>\$ 976,660</u>	<u>\$ 867,099</u>
Council expenses:		
State governmental activities	\$ 59,617	\$ 64,250
Federal governmental activities	23,765	27,856
Medical education	(436)	1,081
Medical services	142	(7,450)
Member services	(16,646)	(9,110)
Planning and development	2,872	4,366
Professional and public relations	16,416	26,601
Public and mental health	1,194	126
Hospital medical staffs	369	111
Total council expenses	<u>\$ 87,293</u>	<u>\$ 108,837</u>

**Oklahoma State Medical Association and Subsidiary
Consolidated Schedule of Expenses**

	Years ended December 31,	
	1986	1985
JOURNAL expenses:		
Salaries	\$ 36,000	\$ 36,000
Advertising	14,602	15,720
Artwork	3,551	5,580
Printing	70,236	63,450
Proofreading	1,088	1,019
Supplies and other	10,969	6,319
Total before allocation of overhead	136,446	128,088
Overhead allocated from general membership expenses	39,805	34,974
Total JOURNAL expenses	\$176,251	\$163,062
Annual meeting expenses:		
Exhibit expense	\$ 808	\$ 92
Travel	146	6
Special events	600	3,022
Printing	5,433	8,209
Speaker	—	1,878
Entertainment	3,600	1,250
Luncheon	18,691	1,164
Signs and security	1,359	1,508
Audio visual equipment	2,951	3,926
Sports activities	700	965
Hotel	16,594	29,498
Ladies activities	—	3,197
Other	6,199	4,463
Total before allocation of overhead	57,081	59,178
Overhead allocated from general membership expenses	33,637	33,329
Total annual meeting expenses	\$ 90,718	\$ 92,507

**Oklahoma State Medical Association
Balance Sheet
March 31, 1987**

Current Assets	
Cash	\$ 2,542
Savings accounts and certificates of deposit	1,692,757
Accounts receivable	489,052
Accounts receivable — Insurance premium refund	370,000
Prepaid expenses	9,981
Total Current Assets	2,564,332
Property and Equipment	
Land	7,808
Building	384,998
Furniture, fixtures and equipment	113,250
Computer Study (EDP System)	21,357
Equipment under capital lease	15,330
	542,743
Less: Accumulated depreciation/amortization	95,866
	446,877
Investment in Subsidiary	4,054,197
Investment in OSMA Member Service Corp.	3,000
Other Assets	
Loan acquisition costs — net of amortization	3,294
TOTAL	\$7,071,700
Current Liabilities	
Current portion of long-term liabilities	\$ 8,132
Accounts payable	920,875
Loan and scholarships payable	12,900
Student fund	683
Deferred income — Dues	494,764
Total Current Liabilities	1,437,354
Long-Term Liabilities	
Notes payable	125,782
Less: Current portion included above	8,132
	117,650
Fund Balance	
Unappropriated	5,516,696
TOTAL	\$7,071,700

**Oklahoma State Medical Association
Statement of Changes in Fund Balance
for the Months Ended March 31, 1987**

Unappropriated	
Beginning of period	\$5,464,280
Excess of revenue over expenses	52,416
End of period	\$5,516,696



Guests scramble to get their bets down before the race begins. At the end of the day, one of the three big money winners will take home the portable TV seen here.

Oklahoma State Medical Association
Statement of Revenues and Expenses
for the Months Ended March 31, 1987

Operations	
Revenue	\$ 206,337
Expenses	221,146
Excess of Expenses over Revenue From Operations	(14,809)
JOURNAL	
Revenue	26,608
Expenses	38,557
Excess of Expenses over Revenue From JOURNAL	(11,949)
Annual Meeting	
Revenue	5,100
Expenses	755
Excess of Revenue over Expenses From Annual Meeting	4,345
Other Revenue (Expenses)	
Excess of reimbursement over expenses for subsidiary	74,829
Net Excess of Revenue over Expenses	\$ 52,416

Oklahoma State Medical Association
Schedule of Revenues
for the Months Ended March 31, 1987

Operations	
Membership dues	\$157,421
Interest	21,501
Commissions	14,779
Building lease	7,200
Membership directory sales and advertising	3,053
Computer label sales	2,383
Total Revenue from Operations	\$206,337
JOURNAL	
Subscriptions and sales	\$ 7,816
Advertising	18,792
Total Revenue from JOURNAL	\$ 26,608
Annual Meeting	
Contributions	\$ 2,450
Ticket sales	2,650
Total Revenue from Annual Meeting	\$ 5,100

Oklahoma State Medical Association
Schedule of Expenses
for the Months Ended March 31, 1987

General Membership Expenses	
Salaries	\$ 80,448
Retirement	2,035
Awards and contributions	3,108
*Councils	13,083
Depreciation and amortization of leased equipment	18,721
Dues and subscriptions	570
Equipment rental	5,256
Insurance	9,110
Interest	3,123
Legal	300
Office supplies	5,851
Out-of-state travel and AMA convention	11,617
Payroll taxes	6,420
Postage and shipping	21,381
Repairs and maintenance	1,531
Services	836
Staff and officers	4,997
Telephone and utilities	8,539
Other general expense	2,706
Newsletter	1,260
Computer supplies	1,681
Directory	-0-
Auxiliary	905
Return-to-Reason	10,708
Special Olympics	(3,990)
OSMA film project	569
Physicians Recovery Program	10,381
	221,146
Excess of reimbursement over expenses for subsidiary	74,829
Total General Membership Expenses	\$146,317

Council Expenses* (included above)	
Governmental activities	\$ 6,905
State legislation	19,060
Professional and public relations	2,068
Medical education	(700)
Medical services	(464)
Member services	(14,005)
Public and mental health	219
Total Council Expenses	\$13,083

The preliminary races are on tape; the money isn't real. But that doesn't seem to dampen anyone's enthusiasm. It's still Derby Day, and the excitement is contagious.



**Oklahoma State Medical Association
Schedule of Expenses
for the Months Ended March 31, 1987**

JOURNAL Expenses

Salaries	\$ 9,000
Printing	20,896
Advertising	4,624
Art work	543
Proofreading	216
Operating	3,278
Total JOURNAL Expenses	\$38,557

Annual Meeting Expenses

Entertainment	\$ 652
Printing	103
Total Annual Meeting Expenses	\$ 755

**Oklahoma State Medical Association
Schedule of Revenues
March 31, 1987**

Operations

Dues	\$157,421
Interest	21,501
Commissions	14,779
Building lease	7,200
Membership Directory Sales	3,053
Computer Label Sales	2,383
Subtotal	\$206,337

Excess Reimbursement over Expenses from
Contract with Subsidiary

74,829

Net from Operations	\$281,166
Less General Membership Expenses	221,146
	\$ 60,020

JOURNAL

Revenue	\$ 26,608
Expense	38,557
	\$(11,949)

Annual Meeting

Revenue	\$ 5,100
Expenses	755
	\$ 4,345
Net from Operations	\$ 52,416



A winner! Kevin Walker, left, director of medical society relations for the AMA, celebrates with OSMA Executive Director David Bickham.

**Oklahoma State Medical Association
Schedule of Expenses
March 31, 1987**

General Membership Expenses

Salaries	\$ 80,448
Pension and Retirement	2,035
Awards and Contributions	3,108
*Council and Program Expense	34,741
Depreciation	18,721
Dues and Subscriptions	570
Equipment Rental	5,256
Insurance	9,110
Interest	3,123
Legal	300
Office Supplies	5,851
Out-of-State Travel and AMA Conventions	11,617
Payroll Taxes	6,420
Postage and Shipping	21,381
Repairs and Maintenance	1,531
Services	836
Staff and Officers	4,997
Telephone and Utilities	8,539
Other General Expense	2,706
Newsletter	1,260
Computer Supplies	1,681
Directory	905
Auxiliary	(3,990)
Total Expenses	\$221,146

***Council and Program Expense (included above)**

Governmental Activities	\$ 6,905
State Legislation	19,060
Professional and Public Relations	2,068
Medical Education	(700)
Medical Services	(464)
Member Services	(14,005)
Public and Mental Health	219
Physician Recovery Program	10,381
OSMA Film Project	569
Return-to-Reason	10,708
Total Council and Program Expense	\$ 34,741



OSMA Proposed Budget
1987

Revenues

Dues	\$630,000
Interest	70,000
Commissions	23,000
Building Lease	30,000
Membership Directory	15,000
Dividends from Subsidiary	25,000
Contracts	300,000
Sales	5,000
Total from Operations	\$1,098,000

JOURNAL

Subscriptions and Sales	\$ 32,000
Advertising	80,000
Total from JOURNAL	\$ 112,000

Annual Meeting

Ticket Sales	\$ 12,000
Contributions	10,000
Total from Annual Meeting	\$ 22,000

Total from all Association Operations \$1,232,000

Council and Program Expense

State Legislation	\$ 65,000
Governmental Activities	27,500
Medical Education	500
Medical Services	500
Member Services	500
Planning and Development	3,000
Professional and Public Relations	45,000
Public and Mental Health	1,200
Hospital Medical Staff Section	500
Resident Activities	3,000
Student Activities	8,500
Young Physician Section	3,000
Auxiliary Activities	8,000
Physician Recovery Program	75,000
Total Council and Program Expense	<u>\$241,200</u>

Expenses

General Expense	
Salaries	\$352,000
Retirement	20,000
Awards and Contributions	2,000
Council and Program Expense	241,200
Depreciation and Amortization of	
Leased Equipment (?)	12,000
Dues and Subscriptions	5,000
Equipment Rental	36,000
Insurance	38,000
In-State Travel	2,500
Interest	12,500
Legal and Professional	15,000
Office Supplies	25,000
Out-of-State Travel and AMA Conventions	65,000
Payroll Taxes	24,000
Postage and Shipping	37,000
Repairs and Maintenance	10,000
Services	6,000
Staff and Officers	30,000
Telephone and Utilities	40,000
Computer Supplies	4,000
Directory	10,000
Computer Maintenance	2,400
Total General Expense	<u>\$989,600</u>

1987 STATE MEDICAL ASSOCIATION DUES

State	Dues	State	Dues
Alabama	\$250	Montana	\$370
Alaska	400	Nebraska	285
Arizona	375	Nevada	180
Arkansas	300	New Hampshire	275
California	340	New Jersey	330
Colorado	555	New Mexico	250
Connecticut	275	New York	275
Delaware	205	North Carolina	350
DC	615	North Dakota	270
Florida	300	Ohio	295
Georgia	335	Oklahoma	210
Hawaii	505	Oregon	325
Idaho	394	Pennsylvania	300
Illinois	273	Puerto Rico	220
Indiana	235	Rhode Island	400
Iowa	300	South Carolina	220
Kansas	220	South Dakota	350
Kentucky	400	Tennessee	220
Louisiana	235	Texas	235
Maine	375	Utah	285
Maryland	255	Vermont	225
Massachusetts	260	Virginia	300
Michigan	290	Washington	398
Minnesota	400	West Virginia	300
Mississippi	235	Wisconsin	465
Missouri	300	Wyoming	320

Report of the COUNCIL ON PLANNING AND DEVELOPMENT

Subject: Annual Meeting Report

Presented by: Elvin M. Amen, MD, Chairman

Referred to: Reference Committee I

Introduction

The Council on Planning and Development is charged with the responsibility of studying and recommending long-range objectives for the OSMA and assessing and making recommendations regarding the resources and programs necessary to reach the objectives. Council membership consists of all of the OSMA general officers, the delegates and alternate delegates to the AMA, and the chairmen of all other association councils and committees.

By tradition, the Council has met twice a year. However, during the 1986-1987 year, the Council met only once to help reduce overall Council costs, as well as to accommodate Council members in a very busy year. The following report is broken down by the various OSMA Councils and contains the minutes and actions taken during the fall meeting of the Council on Planning and Development.

Council on Member Services

William O. Coleman, MD, Chairman, reported that 75% of the Council's time is being spent on underwriting PLICO. The remaining 25% involves activities within the "for-profit" corporation. The Council commends Dr Coleman and his colleagues for their efforts and services provided through this Council.

Council on Medical Services

Ronald S. Barlow, MD, Chairman, stated that his Council is continuing to address fee disputes and appropriateness of care issues. Council stated that it is reviewing various advertising issues at the present time. The Council on Planning & Development recommends the formation of an ad hoc committee to study the problem of advertising and the interference in medical practices by third parties. The Council further recommends that problems associated with Medicaid claims processing be reviewed and reported on via the OSMA newsletter.

Council on Professional and Public Relations

M. Joe Crosthwait, MD, Chairman, reviewed the Council on the numerous positive responses from the OSMA-produced film, *Preserving Tradition, Embracing Change*. The Council commends Dr Crosthwait for the production of this film and the growing distribution of the film throughout the country. The council suggested that the idea of a \$25.00 assessment, to continue the film projects, may be a topic of consideration by the OSMA House of Delegates.

Council on Public and Mental Health

Robert M. Mahaffey, MD, Chairman, reported that the Council is working in concert with the Physician Manpower Training Commission to secure additional psychiatry residency positions in Oklahoma. Dr. Mahaffey stated that his council continues to study perinatal care and AIDS issues.

The Council on Planning and Development recommends that the Council draft a resolution for the OSMA House of Delegates asking that the Governor's Perinatal Task Force be continued under the new administration.

Council on Medical Education

Irwin H. Brown, MD, Chairman, stated that his Council is meeting with everyone concerned with the proposed Nurse Practice Act of Oklahoma. Dr Brown stated that the Council will continue to monitor all activity regarding physician manpower actions and studies, as well as continue in its quest of resurveying institutions to produce medical education programs throughout Oklahoma.

Council on State Legislation

Larry L. Long, MD, Chairman, reported that David Bickham was nominated by the Speaker of the Oklahoma House of Representatives to serve on an interim committee to study the reorganization of state government. The Council on Planning and Development congratulates Dr Long on his nomination, by Senator Rodger Randle, to serve on the Select Committee on Insurance Rates and Tort Claims and commends the Council on their numerous legislative efforts.

Oklahoma Medical Political Action Committee

Larry L. Long, MD, Chairman, reported that OMPAC's membership in 1986 exceeded any previous year. Dr Long commended the OSMA membership for their participation and their willingness to donate time and money in the political arena. He further stated that OMPAC will continue to build membership and will make every effort to build political awareness in the medical profession.

The Council on Planning and Development commends OMPAC for their highly successful election year activities.

Council on Governmental Activities

Perry A. Lambird, MD, Chairman, reported that Oklahoma will eventually be one of seven states that will participate on an assignment fee-for-service basis with CHAMPUS. The project will be carried out over a three-year period. Dr Lambird states that his Council will continue to monitor and make comment on all pertinent congressional actions relating to health issues.

Return to Reason

David Bickham reported that the Coalition has begun negotiations with the State Chamber of Commerce in an effort to build additional support for tort reform. It was reported that every effort will be made to pass meaningful tort reform in the next legislative session.

Respectfully submitted,
Elvin M. Amen, MD, Chairman
Norman L. Dunitz, MD
M. Joe Crosthwait, MD
Ray V. McIntyre, MD
Raymond L. Cornelison, Jr., MD
Larry L. Long, MD
Robert G. Perryman, MD
Thomas N. Lynn, Jr., MD
Rollie E. Rhodes, Jr., MD
William O. Coleman, MD
Ronald S. Barlow, MD
William E. Harrison, Jr., MD
Perry A. Lambird, MD
Irwin H. Brown, MD
Robert M. Mahaffey, MD
Floyd F. Miller, MD
Ed L. Calhoon, MD
Victor L. Robards, Jr., MD
John R. Alexander, MD
Arnold G. Nelson, MD
James B. Pitts, Jr., MD
John A. McIntyre, MD
Michael J. Haugh, MD
George H. Kamp, MD
Mark R. Johnson, MD
J. B. Eskridge III, MD
Orange Welborn, MD
Robert W. Baker III, Staff

Report of the CONSTITUTION AND BYLAWS COMMITTEE

Subject: **Annual Report**

Presented by: Floyd Miller, MD, Chairman

Referred to: Reference Committee I

Introduction

The Constitution and Bylaws Committee is charged with the responsibility of considering all proposed amendments to the Association's Constitution and Bylaws to assure that they are in appropriate form and, if adopted, do not cause conflicts with other portions of the two documents. The Committee may originate proposed amendments, or consider amendments proposed by component societies or individual members of the Association and shall then present them with its recommendations to the House of Delegates for consideration.

In addition, this past year the Committee supervised the re-publication of the Constitution and Bylaws of the OSMA as amended through May of 1986. Copies of the two documents, in a single booklet, have now been distributed to all OSMA officers, members of the Board of Trustees, AMA Delegates, and members of the House of Delegates.

Only one proposed amendment to the OSMA Bylaws has been brought to the Committee's attention this year. This calls for the creation of a "Young Physicians Section" similar to the special sections for Medical Students, Resident Physicians, and Hospital Medical Staff created last year.

Young Physicians Section

In order to create a Young Physicians Section, it is only necessary for the House of Delegates to amend the section representation portion of the Bylaws found in Chapter IV dealing with the House of Delegates. The following suggested Bylaws amendment would accomplish the creation of this special section.

Chapter IV of the OSMA Bylaws is hereby amended by inserting the phrase "Young Physicians Section," between the colon and the phrase "Medical Student Section" in Section 1.04 of Chapter IV.

Recommendation

It is the recommendation of the Constitution and Bylaws Committee that this proposed amendment be adopted.

Respectfully submitted,
Floyd F. Miller, MD, Chairman
Larry L. Long, MD, Vice-Chairman
David Browning, Jr., MD
Jerold D. Kethley, MD
Arnold G. Nelson, MD
J. B. Wallace, MD



A familiar sight in the OSMA House of Delegates — Speaker Larry L. Long, MD, Oklahoma City, at the podium.

Report of the AD HOC COMMITTEE ON YOUNG PHYSICIANS

Subject: **Annual Meeting**

Presented by: James C. King, MD, Chairman

Referred to: Reference Committee I

Recognizing the importance and involvement of young physicians in organized medicine, the American Medical Association, in June of 1986, created the AMA Young Physicians Section. Following the creation of the section, the AMA encouraged each state medical association to appoint a delegate and alternate delegate to represent each state in the AMA Young Physicians Section.

Prior to the AMA Interim meeting of the House of Delegates, Norman L. Dunitz, MD, OSMA president, appointed Lee Newcomer, MD, (Tulsa) Delegate and Robert Bowman, MD, (Nowata) Alternate Delegate to the AMA Young Physicians Section. During the first meeting of the AMA Young Physicians Section, Oklahoma's prominence was easily recognized when Robert Bowman, MD, and Lee Newcomer, MD, were voted to represent the AMA Section as Delegate and Alternate Delegate respectively in the AMA House of Delegates.

On their return from the Interim meeting, Dr. Newcomer and Dr. Bowman organized the Ad Hoc Committee to pursue the creation of an Oklahoma Young Physicians Section within the OSMA.

The Ad Hoc Committee respectfully asks that the report of the Constitution and Bylaws Committee be approved, and we urge the OSMA House of Delegates to approve the addition of the Young Physicians Section in the Oklahoma House of Delegates.

Respectfully submitted,
James C. King, MD, Chairman
Lee Newcomer, MD
Robert Bowman, MD
Ward Hardin, MD
Philip Mosca, MD
James Hutton, MD
Robert W. Baker, III, OSMA Staff

Report of the PHYSICIANS LIABILITY INSURANCE COMPANY

Referred to: Reference Committee I

Physician's Liability Insurance Company was incorporated in 1979 in response to a medical malpractice insurance crisis involving the high cost of professional liability insurance coverage. PLICO issued its first policy January 1, 1980. We are pleased to report that PLICO has now successfully completed its seventh year serving the needs of Oklahoma physicians. In the meantime, cost has become less important nationwide than availability as the few professional liability underwriters who are left have suspended their activities.

Under the strong leadership of the OSMA Board of Trustees and the PLICO Board of Directors, PLICO continues to play the essential role for which it was designed. The financial stability of PLICO assures that safe and secure professional liability and accident and health protection will continue into the future.

Professional Liability Program

The Board of Directors of PLICO reluctantly increased premiums by 10% for the 1987 policy year on January 1, 1987. PLICO continues to offer occurrence insurance to physicians. Occurrence coverage means that once you have paid your premium you are covered ever after for claims that may originate from the period the policy was in force. This means you can leave the state, retire from your profession or simply cease to purchase malpractice insurance and know that no claims from past policy periods will destroy your economic future.

As far as we know, PLICO is the last professional liability insurer in the United States to write this type of coverage. Because your insurance company affords its policyholders this unusual security, it is essential that our rating and premium charges be correct to fund losses.

In 1986, your Board has secured the services of independent actuaries to confirm our own actuarial projections and is pleased to report that their studies support those made by our management company regarding premium requirements. We are not pleased that premium had to be increased this year. We feel strongly that the quality of medical care and its availability will ultimately depend to an important degree upon the price of medical malpractice insurance, especially in the rural areas of Oklahoma. All of us are caught between reducing income and increasing cost.

To continue to afford Oklahomans the readily available first class medical care to which they have become accustomed, the future cost of malpractice insurance must be controlled. We as an association, through the formation and diligent management of PLICO, have done everything we can from our side to achieve controlled professional liability costs. Now, it is up to our state legislature to help us. We trust they will.

Professional Liability Classifications

In recent months, there has been an increased interest in the PLICO rating system. Why does our company use the same rating system used by other insurers which appears to be inequitable?

There are three reasons why PLICO uses the Insurance Services Office (ISO) rating system:

1. It would be impossible to purchase reinsurance if we used any other rating system.
2. There are not enough physicians in any specialty group in Oklahoma to make a large enough universe to create rate stability. If classifications were assigned only on Oklahoma experience, there would be gigantic year-to-year fluctuations in premium for every physician regardless of his specialty that would work economic hardships.
3. All other companies rely on ISO class differentials or something closely akin to them. If a competitive environment should occur again as it has in the past, to keep the participation in PLICO near 100%, we need to line up evenly.

Oklahoma discounts are given equally to every class of physician, but those discounts are discounted off national class differentials.

Insurance rates are not made with medical considerations in mind. Your rates and premiums start in the courtroom, not in the operating theatre. They are made by loss experience, and loss experience frequently does not track with conventional medical wisdom. Because of this, from time to time there are apparent inequities. If one endeavors to determine why rates are higher or lower for classifications or individuals, starting from the proposition that medical risk makes these rates, one will invariably reach the wrong conclusion. Doctors do not make the classifications alone. The plaintiff's bar plays an important role because they feel some classes of cases are easier for them to successfully litigate, i.e. bad babies, unsuccessful fracture reductions, etc.

We recognize these apparent inequities. This is one of the problems of doing business in an imperfect world. They must not threaten the strength of our group or its cohesiveness. By sticking together, we have saved ourselves millions of dollars over the last seven years. Many of these millions were saved because our operating costs are so much lower than those of commercial carriers. Many millions were saved because the income from invested surplus, capital and claims reserves have all gone back into the company to defray premium costs, and many were saved because of the close supervision your company has exercised over the defense of claims. To continue to accomplish these savings, we must remain united.

Even with the latest rate increase, PLICO's rates continue to remain lower than those of any other medical malpractice insurers. Currently, we understand that the competition is not writing new physicians in Oklahoma. The only other policies available in Oklahoma are on the claims-made form.

As of December 31, 1986, since the company was formed, 2648 professional liability claims have been reported. During the year 1986, 480 claims were reported; 145 claims were paid for a total of \$15,303,526; \$7,255,991

of this was paid by PLICO and \$8,047,535 was paid by PLICO's reinsurer.

A total of 459 claims have been paid since PLICO was founded on January 1, 1980, through December 31, 1986. The total amount of those claims is \$40,651,453; \$22,499,140 was paid by PLICO and \$18,152,313 was paid by PLICO's reinsurers.

The investment income for 1986 totaled \$3,919,941. This compares to an investment income in 1985 of \$3,475,929. PLICO has enjoyed an investment income since it was founded of \$16,133,282. Most of its investments have been placed in A-rated corporate bonds rather than insured Certificates of Deposit. This investment income is entirely utilized to defray claims costs and company operation expenses so that our premiums can be reduced. Every PLICO policyholder gets \$1.12 worth of insurance for every dollar of premium he pays each year.

In 1986, PLICO negotiated for commutation of loss with General Reinsurance Company, which maintained reinsurance coverage on behalf of PLICO from the formation of the company until the end of 1985. This means that now the preponderance of losses from those years has been reported and that General Reinsurance Company was willing to pay a price to be agreed upon in order to remove additional exposure from its records.

In late 1986, a price was agreed upon and commutation was recommended by the management company, approved by the Board of PLICO which recommended commutation to the Board of Trustees acting on behalf of the membership. The Board of Trustees approved commutation, and PLICO assumed the loss exposure for all of the risk of GenRe, save the year 1984 where that risk was limited to

\$1,000,000 per insured loss in exchange for \$8,770,000. The policy year 1985 remains under a reinsurance contract with General Reinsurance Company with a retention of \$350,000.

PLICO's 1987 financial statement will reflect this unusual income item. It is not reflected in this 1986 Annual Report as the transaction occurred after January 1, 1987.

Loss Control

The PLICO Board decided to require attendance of the Loss Prevention Seminars effective January 1, 1986. This is because the Board firmly believes that physicians insured by PLICO for professional liability can benefit from these seminars and because these seminars can be used to satisfy national standards which are currently being imposed in this regard. The premium discount that was offered to those who attended these seminars in the past will, it is hoped, become an overall discount in the premium because of the increased awareness and knowledge of all Oklahoma physicians resulting from this extended education.

Underwriting

PLICO is unique even among the physician owned captive insurance companies. The Underwriting Committee is entirely composed of physicians. Their review of claims and the activities that cause the claims drives the underwriting of PLICO. All premium surcharge and underwriting decisions involving individual physicians are made by our peers. The Underwriting Committee meets on a regular basis and reviews those physicians with loss experience. The committee studies the claim files involving all open claims and all settled or litigated claims. At the direction of PLICO, this review is confined to a search for any indication of aberrant medical practice, and no surcharges are now made nor policies limited unless there is a belief on the part of the physicians on the Underwriting Committee that there was actual negligence on the part of the physician being reviewed. No surcharges or termination of coverage take place until the PLICO Board has reviewed the recommendation of the committee, and then that recommendation is subject to appeal. The physician involved has the opportunity to appeal and has the opportunity to come before the Board and explain his side of the case.

The reason PLICO has adopted this laborious and time-consuming system is to eliminate the arbitrary decisions that are made so frequently by commercial insurers and to guarantee as nearly as is possible the fairest treatment of each individual doctor. With PLICO, a decision is never made by an insurance underwriter regarding a physician's destiny. These decisions are made by our peers. With PLICO, the decisions are made on the basis of the quality of medical practice not just on the number of lawsuits or the amount of dollars involved. PLICO's philosophy is the basic philosophy of insurance, and that is that all of us share the risk with those unfortunate few who suffer loss and that only those physicians who are deemed by their peers to have deviated from acceptable standards should be penalized in any way.

Because nine out of ten professional liability lawsuits that go to trial are won by PLICO, and because many files



Thomas N. Lynn, Jr., MD, chairman of the OSMA Board of Trustees, presides over the board's Friday morning meeting.



OSMA President M. Joe Crosthwait, MD, presents a gift of appreciation from the association to Annette Dunitz, wife of retiring President Norman L. Dunitz, MD.

are never pursued by the plaintiff, it is apparent to us all that there are many spurious and non-meritorious claims. The Underwriting Committee's mission is not to penalize physicians for their misfortune in these instances, but it behooves a physician who is penalized, if he feels he has been unjustly treated, to approach the Underwriting Committee with his complaint and to ultimately exercise his right of appeal to the Board of PLICO if that becomes necessary.

You have these rights and enjoy these privileges with PLICO but, of course, you have the responsibility to utilize them when you feel it is appropriate and necessary. All you need do is contact PLICO and you will be afforded the opportunity of review.

We all recognize that there are problem physicians and that they must be dealt with, but PLICO is determined to exercise the utmost fairness in doing so.

PLICO Health Program

There were 2,565 PLICO Health policies in force for physicians and 4,234 policies in force for physicians' employees as of December 31, 1986. This represents 18,104 individuals insured under the PLICO Health Program.

During 1986, there were many HMO and PPO plans that were started who were offering very low premiums. Many offered first dollar coverage with no deductibles. The HMO and PPO plans are beginning to raise their premiums.

This fact along with other points of dissatisfaction with these plans has resulted in their loss of the competitive edge. The most important point to remember about PLICO Health is that you are guaranteed continued insurability no matter what your loss experience becomes so long as you stay with PLICO Health. If a physician drops out of the plan and decides to return, he is subject to underwriting and exclusion of pre-existing conditions for one year.

During 1986, a total of 47,593 health claims were processed, and a total of \$10,685,659 was paid to policyholders. Since PLICO Health's inception, 179,319 claims have been processed with \$41,309,582 in benefits paid to physicians, their families and employees.

Your PLICO Board of Directors continues with its best efforts to provide the broadest coverage possible in both the professional liability and accident and health lines at the lowest possible cost. The PLICO Board of Directors pledges to continue their efforts during 1987.

Physicians Liability Insurance Company Balance Sheet Year Ended December 31, 1986

Assets	
Cash and Invested Assets	\$34,069,679
Premium and Agent Balances in Course of Collection	175,853
Reinsurance Recoverable on Loss Payments	153,681
Interest Receivable	700,805
Receivable from OSMA	752,500
TOTAL ASSETS	\$35,852,518
Liabilities	
Unearned Premium	\$ 4,167,882
Losses and Loss Adjustment Expenses	27,611,865
Miscellaneous Accounts Payable	18,573
TOTAL LIABILITIES	31,798,320
Stockholder's Equity	
Common Stock	150,000
Additional Paid-In Capital	5,600,000
Deficit	(1,695,802)
Total Stockholder's Equity	4,054,198
Total Liabilities and Stockholder's Equity	35,852,518

STATEMENT OF OPERATIONS Year Ended December 31, 1986

Revenues	
Earned Premiums	25,663,998
Investment Income	3,964,928
TOTAL REVENUES	29,628,926
Expenses	
Losses	19,591,032
Loss Adjustment Expenses	5,985,423
Operating Expenses	4,647,709
Total Expenses	30,224,164
Loss	(595,238)
Deficit, Beginning of Year	(1,100,564)
Deficit, End of Year	(1,695,802)

Report of the OKLAHOMA STATE MEDICAL ASSOCIATION AUXILIARY

Subject: **Annual Report**

Presented by: Mrs Kelsey Walters, President

Referred to: Reference Committee I

"Motivate Our Volunteers with Enthusiasm — M.O.V.E. with O.S.M.A.A." was our theme for 1986-87. It has been a fast-paced year, with many innovations and accomplishments. We have learned that by trying to motivate others, we motivated ourselves. Enthusiasm for a job well done is shared by many Auxilians across the state.

There is no better way to experience motivation, purpose, and enthusiasm than to have the opportunity to travel to Chicago for an AMA Auxiliary meeting. In June, our delegation attended the AMAA Annual Convention where we had the opportunity to see Sherry Strebel and Mary Ann Deen conduct workshops, as National Legislation Chairman and Membership Committee Member, respectively. President-Elect Julie Weedn and I returned to Chicago in September for Leadership Confluence I, and Julie went again in February for Leadership Confluence II. We traveled to these meetings with county presidents-elect, and it was a rewarding time for all of us to exchange ideas and aspirations.

The purpose of the OSMAA Fall Confluence is to provide the state membership with a local opportunity for training and stimulation similar to that at a national meeting. The Fall Confluence chairman and her committee did an excellent job achieving this goal. Held at the Park Suite Hotel in Oklahoma City, September 15-16, this year's program focused on women's health issues. Local experts spoke to us on "Teenage Pregnancy," "Anorexia and Bulimia," and "Hormonal Changes in a Woman's Lifetime." Two speakers spoke on "Motivating Volunteers" and "Leadership Styles." In addition, numerous training workshops were conducted for county chairmen. A special effort was made to invite community volunteers and health agency personnel. Over 130 Auxiliary members and guests attended some portion of the meeting.

Communication was a key word this year. I wrote monthly newsletters to the board and members-at-large. State committee chairmen communicated regularly with the county chairmen by writing their own newsletters. The Membership Committee used a team approach, and set goals at a July organizational meeting. In spite of an economic recession in Oklahoma, AMA-ERF raised \$30,148.28 for medical schools in our state. A silent auction is planned for Convention with items donated by county auxiliaries. The Health Projects Committee focused awareness on the teenage pregnancy problem in Oklahoma, and continued with the Medifile Project. In addition, the chairman catalogued all audio and video tapes available at the state auxiliary office into a lending library system, and made these resources known to all county auxiliaries. I attended all OSMA Board of Trustees meetings and reported on Auxiliary activities at each one.

This was a year of "firsts" in many ways. It was the first year to use our new computer program and membership directory. We had our first male County President-Elect, John Johnson from Chickasha, who attended Leadership Confluence I in Chicago. We welcomed a new county auxiliary, Jackson County, to the OSMAA in 1987. Medicine Day at the Capitol was another first, the success of which proves that the OSMA and OSMAA can unite forces for outstanding results.

Medicine Day was initiated as a cooperative effort to involve physicians and spouses in legislation affecting medicine. The response was superb — 341 physicians, spouses, residents, and friends of medicine attended the February 18 event. Over 700 lunches were served to participants, legislators, and their staffs. Medical specialty societies set up exhibits in the Rotunda, and Governor Bellmon and House and Senate leaders spoke to the assembled group in the House of Representatives Chamber.

A commitment to legislative involvement was sustained all year. The Legislative Action Committee held an all-day workshop in August on the legislative process. A statewide phone bank was formed to respond to state and national medical legislation alerts. Auxiliary awareness and contributions for OMPAC-AMPAC have continued to increase remarkably. As of December, 1986, 218 Auxilians had contributed; the 1987 membership drive is now in progress. The Auxiliary had excellent representation as voting members on three OSMA committees: OMPAC-AMPAC; the Council on State Legislation; and the Council on Governmental Activities.

I attended fourteen county auxiliary meetings this year, all but one with Julie Weedn. It was a wonderful opportunity to share Auxiliary goals, make new friends, and learn about so many excellent community projects. Julie's strong leadership abilities and experience in Auxiliary are assets that insure continued success.

Without the support and assistance of the president, board, and staff of the OSMA, the Auxiliary could not have accomplished so much this past year. Thank you for giving us the opportunity to demonstrate that spouses of physicians care about medical issues and are willing to be involved.

Respectfully submitted,
Kelsey P. Walters
OSMAA President

Report of the OKLAHOMANS AGAINST LAWSUIT ABUSE RETURN TO REASON COALITION

Subject: **Annual Report**

Presented by: Don Blair, OALA Executive Director

Referred to: Reference Committee I

Introduction

In the summer of 1985, the Oklahoma State Medical Association prepared a master plan for a tort reform campaign geared to provide relief for physicians. The plan would begin in 1986.

However, in November of 1985, the OSMA and approximately one dozen other organizations were invited to a meeting called by the Oklahoma Press Association to discuss the liability crisis and future action. It was evident that the liability insurance crisis was more than a physician issue and that legislation would be introduced in 1986.

From this organizational meeting grew the coalition Oklahomans Against Lawsuit Abuse which numbered over 40 businesses and professional associations as members.

The OALA coalition introduced House Bill 1892 during the 1986 legislative session.

This comprehensive bill passed the Oklahoma House overwhelmingly but was severely amended in the attorney-dominated Oklahoma Senate. The amended HB 1892 was returned to the House, which refused to act on it. Instead the House amended SB 488 and sent it back to the Senate. SB 488 ended up in a Joint House-Senate Conference Committee. The resulting compromise produced a cap on punitive damages and made those who brought a frivolous suit or offered a frivolous defense liable for up to \$10,000 of legal fees and court costs.

Activities

In planning legislative activities for the 1987 session, the OALA coalition and the OSMA received a boost from a powerful ally — the Oklahoma State Chamber of Commerce and Industry. Tort reform joined right-to-work at the top of the state chamber's list of priorities.

As bill drafting began, another player favoring tort reform entered the contest, Governor Henry Bellmon.

Working in concert, the Governor's office, the OSMA, OALA, and the State Chamber produced Senate Bill 134, a comprehensive tort reform bill that would have benefited all Oklahomans. A summary of SB 134 is attached to this report.

The bill was assigned to the Senate Rules Committee. A massive lobbying effort began. Members of the Senate Rules Committee were truly inundated with letters and phone calls favoring SB 134.

Physicians, their spouses, families, and staffs deserve much credit for the success of this effort.

Unfortunately, the Senate Rules Committee attorney members led the effort to kill the bill in Committee and deny a fair hearing for the bill by the entire Oklahoma Senate. With Senate leadership reneging on promises to get the bill out, SB 134 died in the Rules Committee by an eleven-to-eleven tie vote.

Efforts then shifted to SB 183, a bill authored by Senator Tim Leonard and supported by many of those who opposed SB 134.

Even opponents of general tort reform admit that physicians and hospitals have a real problem and deserve help.

SB 183 offers some relief for professionals, particularly physicians. The bill provides a seven-year statute of limitations on minors and incompetents; makes those who bring frivolous suits responsible for "reasonable" court



Rick Ernest, executive director of the Oklahoma County Medical Society, follows events in the House of Delegates.

costs; provides immunity for peer review activities; and prohibits announcing the amount sought in a suit other than the minimum necessary to establish the court of jurisdiction. SB 183 awaits final Senate action and the Governor's signature.

A copy of SB 183 follows this report.

Conclusion

Through almost two sessions of the Oklahoma Legislature progress has been made in accomplishing tort reform. Caps exist on punitive damages. Frivolous suits will produce penalties. In medical actions, there is a statute of limitations on minors and incompetents. Physicians and certain other professionals are protected for peer review activities. Juries may now itemize awards. Ad damnum has been eliminated.

All are steps in the right direction.

So far our efforts have been unable to achieve a cap on noneconomic damages, elimination of joint and several liability, and periodic payments of awards. Continued pressure not only from OALA but also the Governor's office will be necessary to attain these objectives.

FINANCIAL SUMMARY
OSMA Tort Reform Effort
1986-87

Tort Reform Assessment	\$500,000
OSMA Contribution & Expenses	<u>104,157</u>
Balance in OSMA Tort Reform Account	<u>\$395,843</u>

Oklahomans Against Lawsuit Abuse
1986-87

Total Income	\$105,511
Total Expense	<u>99,017</u>
Balance OALA Account	<u>\$ 6,494</u>

4/30/87

SENATE BILL 134
Help Correct Our Unfair
Liability Laws
Before It's Too Late!
Reform Proposals: A Return to Reason

Reform of the tort system will restore the rights of both defendants and the premium-paying public which have been taken from us through the legislative-judicial process. Here are the abuses which need correction:

Abuse 1 — "Deep Pocket": If you and two of your neighbors are sued and each of you is found to be one-third at fault, the entire jury award can be collected from you. **Solution:** By law, each one of several defendants in a lawsuit should not be required to pay more than his share of the judgment as determined by his percentage of fault.

Abuse 2 — "Windfall Verdicts": Sensational personal injury awards of a million dollars or more are often derived through the excessive values assigned to unsubstantiated complaints like "pain and suffering," "inconvenience" and "humiliation." Dollars awarded for these unmeasurable damages are sometimes designed to create wealth rather than make the injured party "whole" as our laws once intended. **Solution:** Noneconomic damages should be limited by law to not more than \$250,000.

Abuse 3 — "Punishment and Double Jeopardy": You can be "fined" as punishment for a "reckless act" in addition to other damages you must pay for real injuries or unsubstantiated complaints. Since punitive damages are like a fine for reckless driving, they are normally not covered by your insurance policy. And, under present law, several people can sue you for punitive damages in a series of lawsuits for the same "reckless act." This is "Double Jeopardy." **Solution:** Because of the "fine" aspect of punitive damages, the state and county governments should each receive one-third of such damages with the suing party receiving the remaining third. Punitive damages should only be charged once for the same offensive act.

Abuse 4 — "Cash on the Barrelhead": Today you are required to pay cash for the "future care and keeping" of a person you are accused of injuring. But it would cost you less and the injured party would receive the same benefit if you were permitted to fund a monthly installment plan through a guaranteed income-generating annuity. **Solution:** Give the defendant and all insurance buyers this economical option, and give the injured party the assurance that his money will be there when the bills for future care come due. Studies show that "lump sum" payments are typically exhausted within a few years.

Abuse 5 — "Double-Dipping": Today, your attorney cannot even tell the jury that the health care costs and lost wages of the person suing you have been paid in part or in full by an insurance company or employer. You can be forced to pay damages which have already been paid. **Solution:** The jury should be informed about insurance recoveries which offset damages.

Abuse 6 — "Perpetual Liability": If you manufactured and sold an industrial power saw 40 years ago, and it had been re-sold many times and modified and abused in the process, you could be held responsible for any injuries which occur without regard to time or circumstance. **Solution:** In products liability, we propose no claim may be filed more than two years after an injury nor in any event more than ten years after the product leaves the manufacturer's custody and control.

Abuse 7 — "Product User's Fault": If you manufactured a ladder and someone fell while standing on the top rung of your product, you could not use that person's fault as a defense even though he disregarded your warning label about this hazard. **Solution:** The law should permit the manufacturer to employ the product user's fault as a defense.

Nothing in our bill denies or restricts free access to the courts nor limits the amount of monetary payments which may be awarded by the jury for objectively measurable damages suffered by the plaintiff, including the loss of future income.

ENGROSSED HOUSE AMENDMENT
TO

ENGROSSED SENATE BILL NO. 183 BY: **LEONARD, SHEDRICK, ROZELL, WATSON, FLOYD, GARDENHIRE, HERBERT, FORD, GREEN, PIERCE, SADLER and FISHER of the SENATE and BENSON and BASTIN of the HOUSE**

AN ACT RELATING TO CIVIL PROCEDURE, DAMAGES AND TORTS: AMENDING 12 O.S. 1981, SECTION 96, SECTIONS 8 AND 9, CHAPTER 164, O.S.L. 1984 AND SECTION 11, CHAPTER 164, O.S.L. 1984, AS AMENDED BY SECTION 8, CHAPTER 277, O.S.L. 1985 (12 O.S. SUPP. 1986, SECTIONS 2008, 2009 AND 2011), WHICH RELATE TO ACTIONS BY PERSONS UNDER DISABILITY, RULES OF PLEADING, PLEADING SPECIAL MATTERS AND SIGNING OF PLEADINGS; MODIFYING LIMITATION OF ACTIONS BY PERSONS UNDER DISABILITY IN MEDICAL MALPRACTICE ACTIONS; # # # PROVIDING EMERGENCY EXCEPTION FROM NOTICE AND HEARING REQUIREMENTS; REPEALING 76 O.S. 1981, SECTION 16, WHICH RELATES TO PROTECTION OF MEMBERS OF CERTAIN COMMITTEES WHILE PERFORMING PEER REVIEW; PROVIDING FOR CODIFICATION; PROVIDING SEVERABILITY; PROVIDING AN EFFECTIVE DATE; AND DECLARING AN EMERGENCY.

AUTHORS: Add the following House Coauthors: CAMPBELL, HOLDEN, CRAIGHEAD, HEATON, HUNTER, COZORT and CLARK

AMENDMENT NO. 1. Strike the title, enacting clause and entire bill and insert:

"AN ACT RELATING TO CIVIL PROCEDURE, DAMAGES AND TORTS: AMENDING 12 O.S. 1981, SECTION 96, SECTIONS 8 AND 9, CHAPTER 164, O.S.L. 1984 AND SECTION 11, CHAPTER 164, O.S.L. 1984, AS AMENDED BY SECTION 8, CHAPTER 277, O.S.L. 1985 (12 O.S. SUPP. 1986, SECTIONS 2008, 2009 AND 2011), WHICH RELATE TO ACTIONS BY PERSONS UNDER DISABILITY, RULES OF PLEADING, PLEADING SPECIAL MATTERS AND SIGNING OF PLEADINGS; MODIFYING LIMITATION OF ACTIONS BY PERSONS UNDER DISABILITY IN MEDICAL MALPRACTICE ACTIONS; MODIFYING DEMAND FOR JUDGMENT IN CIVIL PLEADINGS; MODIFYING PLEADINGS FOR SPECIAL DAMAGES; PROVIDING THAT CERTAIN PLEADINGS, MOTIONS AND PAPERS BE SIGNED BY AN ATTORNEY OF RECORD OR PARTY; PROVIDING THAT PLEADINGS NEED NOT BE VERIFIED OR ACCOMPANIED BY AFFIDAVIT; PROVIDING THAT SIGNATURE OF ATTORNEY OR PARTY CONSTITUTES CERTIFICATE THAT CERTAIN CONDITIONS HAVE BEEN MET; PROVIDING SANCTIONS FOR ABSENCE OF SIGNATURE AND FOR VIOLATION OF RULE AND PROVIDING EXCEPTION; PROVIDING FOR SEVERAL LIABILITY IN CERTAIN CIRCUMSTANCES; PROVIDING FOR JOINT LIABILITY IN CERTAIN CIRCUMSTANCES; DEFINING TERMS; PROVIDING CERTAIN IMMUNITY FOR PROFESSIONAL REVIEW BODIES AND PERSONS SUPPLYING CERTAIN INFORMATION TO SUCH BODY; PROVIDING EXCEPTIONS; PROVIDING CONDITIONS AND PROCEDURES FOR PROTECTION FROM LIABILITY; PROVIDING REBUTTABLE PRESUMPTION OF CORRECTNESS OF PROFESSIONAL REVIEW ACTION; PROVIDING FOR NOTICE AND HEARING; PROVIDING CERTAIN RIGHTS OF PROFESSIONAL BEING REVIEWED; PROVIDING EMERGENCY EXCEPTION FROM NOTICE AND HEARING REQUIREMENTS; REPEALING 76 O.S. 1981, SECTION 16, WHICH RELATES TO PROTECTION OF MEMBERS OF CERTAIN COMMITTEES WHILE PERFORMING PEER REVIEW; PROVIDING FOR CODIFICATION; PROVIDING SEVERABILITY; PROVIDING AN EFFECTIVE DATE; AND DECLARING AN EMERGENCY.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1: AMENDATORY 12 O.S. 1981, Section 96, is amended to read as follows:

Section 96. If a person entitled to bring an action other than for the recovery of real property, except for a penalty or forfeiture, be, at the time the cause of the action accrued, under any legal disability, every such person shall be entitled to bring such action within one (1) year after such disability shall be removed, except that, after the effective date of this section, an action for personal injury to a minor under the age of twelve (12) arising from medical malpractice must be brought by the minor's parent or guardian within seven (7) years of infliction of the injury, provided a minor twelve (12) years of age and older must bring such action within one (1) year after attaining majority, but in no event less than two (2) years from the date of infliction of the injury, and action for personal injury arising from medical malpractice to a person adjudged incompetent must be brought by the incompetent person's guardian within seven (7) years of infliction of the injury, provided an incompetent who has been adjudged competent must bring such action within one (1) year after the adjudication of such competency, but in no event less than two (2) years from the date of infliction of the injury.

SECTION 2. AMENDATORY Section 8, Chapter 164, O.S.L. 1984 (12 O.S. Supp. 1986, Section 2008), is amended to read as follows:



OSMA Executive Director David Bickham and Legal Counsel Ed Kelsay dress to the nines for Saturday night's Inaugural Dinner-Dance.

Section 2008.

GENERAL RULES OF PLEADING.

A. **CLAIMS FOR RELIEF.** A pleading which sets forth a claim for relief, whether an original claim, counterclaim, cross-claim or third-party claim, shall contain:

1. A short and plain statement of the claim showing that the pleader is entitled to relief; and
2. A demand for judgment for the relief to which he deems himself entitled. Every pleading demanding relief for damages in money in excess of Ten Thousand Dollars (\$10,000.00) shall, without demanding any specific amount of money, set forth only that the amount sought as damages is in excess of Ten Thousand Dollars (\$10,000.00), except in actions sounding in contract. Every pleading demanding relief for damages in money in an amount of Ten Thousand Dollars (\$10,000.00) or less shall specify the amount of such damages sought to be recovered.

Relief in the alternative or of several different types may be demanded.

B. **DEFENSES; FORM OF DENIALS.** A party shall state in short and plain terms his defenses to each claim asserted and shall admit or deny the averments upon which the adverse party relies. If he is without knowledge or information sufficient to form a belief as to the truth of an averment, he shall so state and this statement has the effect of a denial. Denials shall fairly meet the substance of the averments denied. When a pleader intends in good faith to deny only a part or a qualification of an averment, he shall specify so much of it as is true and material and shall deny only the remainder. Unless the pleader intends in good faith to controvert all the averments of the preceding pleading, he may make his denials as specific denials of designated averments or paragraphs or he may generally deny all the averments except such designated averments or paragraphs as he expressly admits; but, when he does so intend to controvert all its averments, he may do so by general denial subject to the obligations set forth in Section 4 2011 of this act title.

C. **AFFIRMATIVE DEFENSES.** In pleading to a preceding pleading, a party shall set forth affirmatively:

1. Accord and satisfaction;
2. Arbitration and award;
3. Assumption of risk;
4. Contributory negligence;
5. Discharge in bankruptcy;
6. Duress;
7. Estoppel;
8. Failure of consideration;
9. Fraud;
10. Illegality;
11. Injury by fellow servant;
12. Laches;
13. License;
14. Payment;
15. Release;
16. Res judicata;
17. Statute of frauds;
18. Statute of limitations;
19. Waiver; and
20. Any other matter constituting an avoidance or affirmative defense.

When a party has mistakenly designated a defense as a counterclaim or a counterclaim as a defense, the court on terms, if justice so requires, shall treat the pleading as if there had been a proper designation.

D. **EFFECT OF FAILURE TO DENY.** Averments in a pleading to which a responsive pleading is required, other than those as to the amount of damage, are admitted when not denied in the responsive pleading. Averments in a pleading to which no responsive pleading is required or permitted shall be taken as denied or avoided.

E. PLEADING TO BE CONCISE AND DIRECT; CONSISTENCY.

1. Each averment of a pleading shall be simple, concise, and direct. No technical forms of pleadings or motions are required.

2. A party may set forth, and at trial rely on, two or more statements of a claim or defense alternately or hypothetically, either in one count or defense or in separate counts or defenses. When two or more statements are made in the alternative and one of them if made independently would be sufficient, the pleading is not made insufficient by the insufficiency of one or more of the alternative statements. A party may also state as many separate claims or defenses as he has regardless of consistency and whether based on legal or equitable grounds. All statements shall be made subject to the obligations set forth in Section 4 2011 of this act title.

F. **CONSTRUCTION OF PLEADINGS.** All pleadings shall be so construed as to do substantial justice.

SECTION 3. AMENDATORY Section 9, Chapter 164, O.S.L. 1984 (12 O.S. Supp. 1986, Section 2009), is amended to read as follows:
Section 2009.

PLEADING SPECIAL MATTERS.

A. **CAPACITY.** It is not necessary to aver the capacity of a party to sue or be sued or the authority of a party to sue or be sued in a representative capacity or the legal existence of an organized association of persons that is made a party. When a party desires to raise an issue as to the legal existence of any party or the capacity of any party to sue or be sued or the authority of a party to sue or be sued in a representative capacity, he shall do so by negative averment, which shall include such supporting particulars as are peculiarly within the pleader's knowledge, and he shall have the burden of proof on that issue.

B. **FRAUD, MISTAKE, CONDITION OF THE MIND.** In all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity. Malice, intent, knowledge, and other condition of mind of a person may be averred generally.

C. **CONDITIONS PRECEDENT.** In pleading the performance or occurrence of conditions precedent, it is sufficient to aver generally that all conditions precedent have been performed or have occurred. A denial of performance or occurrence shall be made specifically and with particularity.

D. **OFFICIAL DOCUMENT OR ACT.** In pleading an official document or official act it is sufficient to aver that the document was issued or the act done in compliance with law.

E. **JUDGMENT.** In pleading a judgment or decision of a domestic or foreign court, judicial or quasi-judicial tribunal, or of a board or officer, it is sufficient to aver the judgment or decision without setting forth matter showing jurisdiction to render it.

F. **TIME AND PLACE.** For the purpose of testing the sufficiency of a pleading, averments of time and place are material and shall be considered like all other averments of material matter.

G. **SPECIAL DAMAGE.** ~~When items of special damage are claimed, they shall be stated, but no amount need be alleged.~~ When items of special damage are claimed, their nature shall be specifically stated. In actions where exemplary or punitive damages are sought, the petition shall not state a dollar amount for damages sought to be recovered but shall state whether the amount of damages sought to be recovered is in excess of or not in excess of Ten Thousand Dollars (\$10,000.00).

SECTION 4. AMENDATORY Section 11, Chapter 164, O.S.L. 1984, as amended by Section 8, Chapter 277, O.S.L. 1985 (12 O.S. Supp. 1986, Section 2011), is amended to read as follows:
Section 2011.

SIGNING OF PLEADINGS.

Every pleading of a party represented by an attorney shall be signed by at least one attorney of record in his individual name, whose address shall be stated, or by the party himself. A party who is not represented by an attorney shall sign his pleading and state his address. Except when otherwise specifically provided by rule or statute, pleadings need not be verified or accompanied by affidavit. The signature of an attorney constitutes a certificate by him that he has read the pleading, that to the best of his knowledge, information and belief there is good ground to support it, and that it is not interposed for delay. If a pleading is not signed or is signed with intent to defeat the purpose of this section, it may be stricken as sham and false and the action may proceed as though the pleading have not been served. For a willful violation of this section, an attorney may be subjected to appropriate disciplinary action. Similar action may be taken if scandalous or indecent matter is inserted, motion, and other paper of a party represented by an attorney shall be signed by at least one attorney of record in his individual name, whose address and Oklahoma Bar Association identification number shall be stated. A party who is not represented by an attorney shall sign his pleading, motion, or other paper and state his address. Except when otherwise specifically provided by rule or statute, pleadings need not be verified or accompanied by affidavit. The rule in equity that the averments of an answer under oath must be overcome by the testimony of two witnesses or of one witness sustained by corroborating circumstances is abolished. The signature of an attorney or party constitutes a certificate by him that he has read the pleading, motion, or other paper; that to the best of his knowledge, information, and belief formed after reasonable inquiry it is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and that it is not interposed for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation. If a pleading, motion, or other paper is not signed, it shall be stricken unless it is signed promptly after the omission is called to the attention of the pleader or movant. If a pleading, motion, or other paper is signed in violation of this rule, the court, upon motion or upon its own initiative, shall impose upon the person who signed it, a represented party, or both, an appropriate sanction, which may include an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the pleading, motion, or other paper, including a reasonable attorney's fee.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 24 of Title 76, unless there is created a duplication in numbering, reads as follows:

In Sections 5 through 10 of this act, the following definitions shall apply:

1. "Professional review body" means a public or private body organized in whole or in part for the purpose of maintaining standards of conduct and competence for accountants, architects, chiropractors, chiropractors, dentists, professional engineers, nurses, pharmacists, physicians, psychologists or veterinarians;

2. "Professional review action" means an action or recommendation taken or made by a professional review body which adversely affects a person's ability to perform his profession but shall not include actions taken or recommendations made by a private professional review body against a person who does not have a reasonable connection to the body's sponsoring organization; and

3. "Sponsoring organization" means a professional association or an institution through which persons practice their professions in whole or in part.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 25 of Title 76, unless there is created a duplication in numbering, reads as follows:

A professional review body, members and staff of such professional review body and persons who contract with such professional review body shall not be liable in any way in damages under any law of this state with respect to a professional review action taken in good faith by such professional review body.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 26 of Title 76, unless there is created a duplication in numbering, reads as follows:

Any person who supplies information in good faith and with reasonable belief that such information is true to a professional review body shall not be liable in any way in damages with respect to giving such information to the professional review body.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 27 of Title 76, unless there is created a duplication in numbering, reads as follows:

Protection from liability in damages pursuant to Sections 6 and 7 of this act shall not extend to actions for violation of civil rights or for antitrust.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 28 of Title 76, unless there is created a duplication in numbering, reads as follows:

Protection from liability pursuant to Section 6 of this act shall be available only on the condition that the professional review action is taken or recommendation is made under the following requirements:

A. The action is taken:

1. In reasonable belief that it will maintain or enhance the quality of professional standards of conduct or competence;

2. After reasonable effort to obtain facts pertinent to the matter;

3. After adequate notice and opportunity to be heard are afforded the professional involved; and

4. In reasonable belief that the facts warrant the action.

A professional review action shall be presumed to meet these standards unless the presumption is rebutted by a preponderance of the evidence.

B. The notice required in paragraph 3 of subsection A of this section must:

1. State that a professional review action has been proposed against the professional;

2. Inform the professional, in detail sufficient for him to prepare a defense, of the reasons for the proposed action;

3. State that the professional may request a hearing whether he has been previously contacted about the proposed action or complaint on which it is founded or not;

4. Inform the professional of the time limit of not less than twenty (20) days in which he must request a hearing or lose such right;

5. Explain the hearing procedure that will be used or the choice of procedures available for the professional's choice if a hearing is requested; and

6. State that if a choice of hearing procedures is available, the professional must choose at the time he requests the hearing.

C. If the affected professional requests a hearing on a timely basis, the professional review body must give the professional notice no less than ten (10) days before the hearing of the place, time and date of the hearing, of the witnesses expected to be called against him, and of the exhibits expected to be used against him.

D. At the option of the professional review body, the hearing may be held before:

1. An arbitrator mutually acceptable to the professional and professional review body;

2. A hearing officer appointed by the professional review body provided the hearing officer is not in direct economic competition with the affected professional;

3. A panel of individuals appointed by the professional review body provided the individuals are not in direct economic competition with the affected professional; or

4. The entire professional review body.

E. The professional shall:

1. Have the right to be represented by legal counsel at any stage of the proceedings;

2. Have the right to have a record made of the hearing proceedings, copies of which may be obtained by the professional upon payment of reasonable fees set by the professional review body;

3. Have the right to call, examine and cross-examine witnesses;

4. Have the right to present evidence on his behalf which the arbitrator, hearing officer or chairman of the hearing panel determines is relevant;

5. Have the right to submit a written statement at the conclusion of the hearing;

6. Forfeit his right to a hearing if he fails without good cause shown to attend a properly scheduled hearing for which proper notice has been mailed by certified United States mail, return receipt requested; and

7. Receive a written statement explaining the action or decision not to act of the professional review body.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 29 of Title 76, unless there is created a duplication in numbering, reads as follows:

Where failure to act expeditiously may reasonably result in an imminent danger to the public or individual, a professional review body may immediately act to prevent the danger without conducting a prior hearing or giving notice provided that notice and opportunity for hearing must follow the action within three (3) days.

SECTION 11. REPEALER 76 O.S. 1981, Section 16, is hereby repealed.

SECTION 12. The provisions of this act are severable and if any part or provision shall be held void the decision of the court so holding shall not affect or impair any of the remaining parts or provisions of this act.

SECTION 13. This act shall become effective November 1, 1987.

SECTION 14. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval."

Passed the House of Representatives the 22nd day of April, 1987.

Passed the Senate the _____ day of _____, 1987.

Speaker _____ of the House of Representatives

President _____ of the Senate

PROPOSED TORT REFORM TO CORRECT INEQUITIES OF THE CIVIL JUSTICE SYSTEM

General Tort Reform

Cap on Non-economic Damages

Elimination of Joint and Several Liability

X Restriction on Punitive Damages

Mandatory Periodic Payments

Limitation on Contingency Fee

X Penalties for Frivolous Suits or Defense

Elimination or Modification of Collateral Source Rule

X Requiring Juries to Itemize Findings

X Elimination of the Ad Damnum

Medical Tort Reform

X Statute of Limitations on Minors and Incompetents

X Immunity from Suit for Good Faith Peer Review

X Limit Liability of State Employed Physicians, Residents, and Students

X Statute of Limitations

5/87

Reference Committee II

REPORTS TO THE HOUSE OF DELEGATES

Report of REFERENCE COMMITTEE II

Presented by: John A. Blaschke, MD, Chairman

Mr Speaker and Members of the House of Delegates:

Reference Committee II gave careful consideration to the several items referred to it and submits the following report:

(1) Report of the President

Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the President be filed for information.

Your Reference Committee would like to convey its most sincere gratitude and appreciation to Norman L. Dunitz, MD, for his excellent leadership throughout the past year.

The Reference Committee sincerely appreciates the time and diligence Doctor Dunitz has devoted to Association business, and particularly for his work in Workers Compensation reform.

(2) Report of the Council on Professional and Public Relations

Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the Council on Professional and Public Relations be adopted.

Your Reference Committee would like to commend the Council, M. Joe Crosthwait, MD, Chairman, and Mike Sulzycki, OSMA Associate Director, for outstanding public relations programs and encourages continued distribution of the film, *Preserving Tradition, Embracing Change*, for wide public viewing.

(3) Report of the Council on Public and Mental Health

Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the Council on Public and Mental Health be adopted.

The Reference Committee urges the Council and the Association to embark upon aggressive efforts encouraging public education on the AIDS epidemic, and recommends that specific goals and objectives be set for the Ad Hoc



At the PLICO Loss Prevention Seminar, guest speaker John Reckless, MD, Durham, NC, tells doctors how to cope with a malpractice suit.

Committee on AIDS to insure that the Oklahoma populace is informed about the potential devastating effects of this communicable disease.

The Reference Committee extends its gratitude to George W. Prothro, MD, long-time Chairman of the Council, for his many years of excellent service, and also commends Robert M. Mahaffey, MD, for his excellent leadership as Council Chairman.

(4) *Report of the Council on Medical Education*

Recommendation:

Mr Speaker, the Board of Trustees has instructed the Council, and requested of the higher regents a study on physician manpower in Oklahoma, including the admission of students to the University of Oklahoma College of Medicine and other state medical schools. Testimony before the Council indicated that the number of physicians necessary to care for the Oklahoma citizenry is still inconclusive. Therefore, your Reference Committee recommends that the Council on Medical Education:

- 1) Continue to encourage the higher regents to make definitive decisions concerning admissions to all Oklahoma medical colleges;
- 2) Work closely with the University of Oklahoma College of Medicine officials to insure that there is a proper balance of clinical and practicing physicians represented on the OU College of Medicine's Board of Admissions that will insure that students admitted to medical school meet appropriate academic standards and meet the medical needs of Oklahoma patients; and
- 3) Present testimony to the Legislature and proper education officials supporting a change from a capitation-based funding system to a program-based funding system for medical education.

Reference Committee II would like to commend Irwin H. Brown, MD, Council Chairman, for his excellent leadership.

(5) *Report of the Council on Medical Services*

Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the Council on Medical Services be adopted.

The Reference Committee would like to extend special commendation to Ronald S. Barlow, MD, Council Chairman, for his exceptional service.

(6) *Report of the Oklahoma State Medical Association Medical Students Section*

Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the Oklahoma State Medical Association Medical Students Section be adopted.

The Reference Committee notes that the Association contribution to Oklahoma medical students is approximately \$8,500 per year, which is significant and should be a source of pride to the Delegates and the Association.

Reference Committee II would also like to extend special commendation to Wilson D. Steen, PhD, Professor Emeritus of the OU College of Medicine, for his excellent work in nurturing the Section's growth.

(7) *Report of the Oklahoma Foundation for Peer Review*

Recommendation:

Mr Speaker, your Reference Committee received no written report from the Foundation for consideration. However, we are aware that the Foundation presented a report to the Board of Trustees at its annual meeting on Wednesday. The Association has a long-time record of supporting OFPR activities and recommends that the Foundation be requested to file a written report to the House of Delegates each year.

Mr Speaker, Reference Committee II recommends that this portion of the Report be approved.

(8) *Report of the JOURNAL of the Oklahoma State Medical Association*

Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the JOURNAL of the Oklahoma State Medical Association be filed for information.

The Reference Committee congratulates the Editorial Board and Staff for receiving the Sandoz Award for outstanding medical journalism.

The Reference Committee would also like to congratulate Dr Samuel Sepkowitz on receiving the Charlotte S. Leebron Memorial Trust Award.

(9) *Resolution 2—Annual Health Evaluations for Women*

Recommendation:

Mr Speaker, your Reference Committee recommends adoption of the following Substitute Resolution in lieu of Resolution 2:

"Resolved, That the OSMA go on record as favoring annual Papanicolaou (Pap) smears; and that this resolution be forwarded to the AMA; and be it further

"Resolved, That the OSMA seek an opinion from the AMA Council on Scientific Affairs as to the proper protocol for the examination of asymptomatic females over age 25."



"K" Caldwell, Tulsa, OSMA Auxiliary treasurer for 1987-88, addresses the OSMAA House of Delegates. Earlier, in her capacity as chairman of the Oklahoma AMA-ERF, she distributed over \$33,000 in AMA-ERF funds to the University of Oklahoma College of Medicine, OU Tulsa Medical College, and Oral Roberts University School of Medicine.

(10) *Resolution 3 — VIP Program*

Recommendation:

Mr Speaker, your Reference Committee recommends that the following Substitute Resolution be adopted in lieu of Resolution 3:

"Resolved, That the OSMA study the VIP Program and encourage its implementation by all constituent societies of the association."

The Reference Committee also wishes to commend Tulsa County Medical Society on its efforts toward the "Very Important Patient" Program.

(11) *Resolution 4 — AMA Public Service Announcements*

Recommendation:

Mr Speaker, your Reference Committee recommends that Resolution 4 be adopted.

(12) *Resolution 6 — AMA Delegates Reports*

Recommendation:

Mr Speaker, your Reference Committee recommends that Resolution 6 be adopted.

(13) *Resolution 11 — Creation of a Senior Citizens' Advisory Committee*

Recommendation:

Mr Speaker, your Reference Committee recommends that Resolution 11 be adopted as amended, by adding the following additional resolve on Line 14:

"throughout Oklahoma; and be it further

"Resolved, That county societies be encouraged to also initiate similar advisory committees."

(14) *Late Resolution 12 — Public Relations Activities*

Recommendation:

Mr Speaker, your Reference Committee has carefully considered Late Resolution 12 and recommends that it not be adopted.

Your Reference Committee recommends that the Council on Professional and Public Relations be authorized to develop a comprehensive PR plan with consultation from a professional public relations firm, that details of the plan with funding requirements be presented to the Board of Trustees, and that specific recommendations be made to the House of Delegates at its next annual meeting.

(15) *Resolution 13 — Release of Patient Information*

Recommendation:

Mr Speaker, your Reference Committee recommends that Resolution 13 be adopted.

The Reference Committee recognizes that the release of specific patient information may require the consultation of legal counsel, and encourages the members of OSMA to contact OSMA's staff counsel when in doubt about the release of specific patient medical information, but concurs in the philosophy position of Resolution 13.

(16) *Late Resolution 15 — AIDS Education*

Recommendation:

Mr Speaker, your Reference Committee recommends that the following Substitute Resolution 15 be adopted:

"WHEREAS, The recent dramatic increase in patients with Acquired Immune Deficiency Syndrome is potentially the most serious threat to public health throughout the world; and

"WHEREAS, The prediction of the extent of spread of this fatal disease throughout our population by the end of this decade is unknown; now therefore be it

"Resolved, That the Oklahoma State Medical Association give support to the education of the public in general, as well as to its own members concerning AIDS; and be it further

"Resolved, That the OSMA, through the Ad Hoc Committee on AIDS, help develop educational programs in conjunction with the Oklahoma State Department of Health for members and for the general public."

Mr Speaker, your Reference Committee recommends adoption of the Report of Reference Committee II, as amended, as a whole.

Mr Speaker, this concludes the Report of Reference Committee II. Your Reference Committee wishes to thank all who participated in the hearing and contributed to the preparation of this report.

Respectfully submitted,
John A. Blaschke, MD, Chairman, Oklahoma City
Donald R. Carter, MD, Oklahoma City
Frank W. Clark, MD, Ardmore
Douglas C. Hubner, MD, Tulsa
Arthur E. Schmidt, MD, Oklahoma City
Boyd O. Whitlock, MD, Tulsa
Robert C. Wright, MD, Stillwater
Mike Sulzycki, Staff
Toni Leverett, Staff

Report of the COUNCIL ON PROFESSIONAL AND PUBLIC RELATIONS

Subject: **Annual Report**

Presented by: M. Joe Crosthwait, MD, Chairman

Referred to: Reference Committee II

Introduction

The Council on Professional and Public Relations is responsible for internal and external communications programs of the Oklahoma State Medical Association. The overall goals of the Council are: 1) to improve and maintain understanding among Oklahoma physicians, their patients, and the public; and 2) to keep members informed about programs, policies, and activities undertaken by the Association affecting the practice of medicine in Oklahoma.

Review of Activities

The OSMA documentary film *Preserving Tradition, Embracing Change* was finally completed and previewed at last year's OSMA House of Delegates meeting. Last June the film was shown during the AMA Annual Meeting in Chicago.

A priority for the Council this year was to distribute the film widely. Videotapes of the film have been requested by and sent to 70 state and county medical associations, specialty societies, hospitals, and individuals. Six groups purchased copies of the film at a cost of \$500.00 each.

The film has received a wide audience through these various groups. In addition, the film will be shown on public television in the state of Pennsylvania through the efforts of the Pennsylvania Medical Society. The film has also been shown on television in Texas through the efforts of physicians in Lubbock.

In Oklahoma the film was shown on a statewide basis on Oklahoma Educational Television Authority on October 9. Statement stuffers and posters publicizing the broadcast

were distributed to all physicians in the state. In addition, announcements were purchased in the television sections of newspapers across the state.

The impact of the film on viewers was dramatic. Attached to this report is a scientific survey conducted by the nationally respected polling firm of Tarrance, Hill, Newport, and Ryan of Houston, Texas. The study indicates quite clearly that those who view the film have a much more positive perception of medicine and physicians.

The survey clearly demonstrates the favorable impact effective use of the media has in explaining complex medical issues to the public. The Council also realizes that producing high quality films and announcements is expensive. The Council also realizes that it is becoming increasingly necessary to consider the purchase of broadcast time and newspaper space to convey medicine's message. These costs exceed the Council's normal operating budget.

Therefore, the Council recommends adoption of a resolution, included in this report, which calls for a \$40.00 assessment of each member, earmarked for public relations activities.

In other activities, the Council continued to publish the *OSMA News* and contribute to the *JOURNAL* of the OSMA and work closely with the members of the Oklahoma news media to provide news and public service information to the citizens of Oklahoma.

The Council worked with radio station KTOK in Oklahoma City to provide monthly commentaries on medical topics by the OSMA President.

The Council staff also worked closely with the coalition Oklahomans Against Lawsuit Abuse to produce materials for the tort reform effort including *Tort Reform Weekly*, a newsletter which went to some 1,000 key legislative contacts.

The Council also helped coordinate OSMA medical student activities.

Two goals, unmet in 1986, will be priorities in 1987: production of an OSMA membership brochure and an active Speakers Bureau.

Objectives

- 1) Continue to work for further distribution of film *Preserving Tradition, Embracing Change*.
- 2) Continue monthly radio commentaries on KTOK radio.
- 3) Distribute monthly OSMA radio commentaries on medical matters to other state radio stations.
- 4) Place higher priority on production of new Medical Update brochures.
- 5) Continue to publish *OSMA News*.
- 6) Initiate Speakers Bureau.
- 7) Print OSMA membership brochure.
- 8) Support the public relations and public information needs of the Association, its Councils, and Auxiliary.

9) Produce radio and television public service announcements; none have been produced in the last five years.

10) Work to implement VIP program, introduced by Tulsa County Medical Society, on a statewide basis.

Budget

Print OSMA News	\$10,000.00
Print Medical Updates	4,000.00
Radio Commentaries	7,000.00
Educational Activities and Dues	3,000.00
Print Membership Brochure	6,000.00
Community Service (Charities)	1,000.00
Speakers Bureau	1,000.00
VIP Program	2,000.00
PSA Production	10,000.00
Documentary Videotape Copies	1,000.00
TOTAL	\$45,000.00

Respectfully submitted,
M. Joe Crosthwait, MD, Chairman
Howard A. Bennett, MD
Warren V. Filley, MD
Burdge F. Green, MD
William E. Harrison, Jr., MD
Gary L. Massad, MD
Mary Anne McCaffree, MD
L. Sam Musallam, MD
John W. Phillips, Jr., MD
Lee E. Schoeffler, MD
Michael R. Talley, MD
Lanny F. Trotter, MD
Mrs. Jacque Tomsovic
Melanie Russell, MS IV
Peter Kamp, MS
M. Michael Sulzycki, OSMA

OKLAHOMA STATE MEDICAL ASSOCIATION FILM STUDY OCTOBER 1986

Prepared by
TARRANCE, HILL, NEWPORT, & RYAN
for
THE OKLAHOMA STATE MEDICAL ASSOCIATION

I. Background and Methodology

As part of its ongoing efforts to educate the American public about the many changes affecting health care, the Oklahoma State Medical Association commissioned the production of a 30-minute documentary film entitled *Preserving Tradition, Embracing Change*. This film aired publicly on Thursday, October 9, 1986 at 7:00 PM on OETA across Oklahoma.

To aid in evaluating the film's effectiveness, telephone interviews were conducted the following evening with members of the American Association of Retired Persons (AARP) who had earlier agreed to watch the film (N = 44) and with randomly selected Oklahoma residents 55 years of age and older (N = 216). The interview included 23 questions and required approximately 10 minutes of telephone time.

Because many of the questions had also been included in a study of Oklahoma residents conducted in July 1985, findings can be compared to these earlier data, as well as between individuals who had and had not seen the film.

II. Analysis

The comparative results are presented in Table 1 below. A comparison of the 1985 and 1986 data shows that in most cases, there are not significant differences statistically. However, there is a slight trend toward general improvement in the public image of physicians, as five of eight questions related to physicians indicate some improvement during the year. While senior Oklahomans are significantly less likely now than in 1985 to say that people are losing faith in physicians, they are also significantly less likely to believe that physicians make no more mistakes now than they did 10 years ago. In general, the pattern of trends is mixed.

TABLE 1

		(% Agree)		
	7/85	No Film 10/86	Film 10/86	Δ Film
1. Fees reasonable	27	29	41	+ 12*
2. Losing faith in MDs	66	57	52	+ 5
3. Too interested in money	66	69	59	+ 10*
4. Growing crisis — malpractice	75	70	82	+ 12*
5. MDs don't care	66	62	41	+ 21*
6. Government provide better care	70	74	63	11*
7. Become MDs to help	52	52	61	+ 9
8. MDs spend enough time	31	35	32	- 3
9. Make too much money	69	63	55	+ 8
10. No more mistakes	63	53	66	+ 13*
11. MDs leaving practice	NA	63	71	+ 8
12. Federal cuts close hospitals	NA	72	82	+ 10*
13. MDs fight for quality	NA	66	81	+ 15*
14. \$ spent on health (% not enough)	NA	26	30	+ 4
15. All deserve best care	NA	92	77	15*
16. Cause of health care problems (% MDs and hospitals)	NA	66	57	+ 9

This is certainly *not* the case in comparing the attitudes of those individuals who did and did not see the film, *Preserving Tradition, Embracing Change*. The column labeled Δ film indicates the difference in opinion between the two groups and the + sign denotes improvement from the physicians' perspective.

Of sixteen comparisons, thirteen show improvement in the Oklahoma public's perception of physicians and the health care system, and seven of the thirteen positive differences are statistically significant ($p \leq .1$). Question 8, physicians spend enough time with patients, is largely unaffected by exposure to the film and this is expected because the film does not address that aspect of the MD-patient relationship. The variables that show a significant positive difference between those who did and did not see the film are:

- Doctors' fees are usually reasonable. (+12)
- Doctors are too interested in making money. (+10)
- There is a growing crisis with malpractice suits and awards in this country. (+12)
- Doctors don't care about people as much as they used to. (+21)
- Doctors don't make any more mistakes now than they did 10 years ago. (+13)
- Cuts in federal spending on health care are causing some small rural hospitals to close. (+10)
- Doctors are fighting to keep the quality of medical care high while government keeps cutting back on what they will pay. (+15)

There is a methodological caution that must be made explicit, however. Because respondents were not randomly assigned to the exposure and non-exposure groups, it is possible that those who agreed to watch the film had more positive attitudes toward doctors *before* they saw the film.

This possibility is discounted by the fact that individuals who agreed to watch the film are AARP members, who typically have strong interest in medical care and are usually not well disposed toward physicians and the current health care system. However, the possibility of self-selection bias in the exposure group cannot be refuted statistically.

Responses to two questions,

- The government should provide better health care for the poor and elderly.
- Does every American regardless of income or age deserve the best medical care currently available?

are extremely interesting and bear close scrutiny. In each case, respondents who saw the film are less likely to agree than those who did not. Both differences are strong and statistically significant.

Of course, there are many hypotheses that could account for this pattern of results. One is that the film stresses the concept of *rationing* health care services and emphasizes the fact that under current conditions rationing is impossible to avoid. It may be that the film reinforces a sense that the best possible health care for every American is prohibitively expensive and that some kind of allocation process is necessary. The current system and level of expenditure could be viewed as adequate.

In general, ratings of the film itself are very positive. More than half of those who viewed the film gave it an excellent rating and fewer than 14% said the program was only fair. No one indicated that the film was poor. Two of three viewers believed that the presentation of problems within the film was balanced and fair while almost 80% of viewers said the film was either very or somewhat effective in educating people about problems with the current health care system. Finally, 82% of Oklahomans who saw the program indicated that they would recommend it to their friends and neighbors if it were to be aired again.

PROFESSIONAL AND PUBLIC RELATIONS

Summary

This statistical evaluation demonstrates that, in the short term, the film *Preserving Tradition, Embracing Change* produced by the Oklahoma State Medical Association is effective in improving the attitudes of senior citizens toward physicians and educating them about some of the basic causes of problems in the health care system today. The long term impact of film viewership cannot be estimated within these data, but is likely to be largely determined by successive repeat exposure.

The film also imparts a more realistic sense of how and why health services are rationed and reinforces the view that the best medical care cannot be available to everyone. The program also increases the elderly public's sensitivity to the professional liability crisis and improves their evaluation of physicians' practice economics.

Viewers give the program itself high ratings for educational value, balance and fairness in presenting problems, and in general. More than eight in ten say they would recommend the film to friends and neighbors if it were to be shown again.

In summary, *Preserving Tradition, Embracing Change* shows itself to be an excellent communications vehicle for increasing the public's understanding of the complex, intricate issues and problems facing the health care system today.

INTERVIEWER _____ STUDY # 2950
TARRANCE & ASSOCIATES _____ TIME STARTED _____
PERSONAL/CONFIDENTIAL _____ TIME ENDED _____
FINANCE _____
CODING _____

Hello, I'm _____ of Tarrance & Associates, the nationally known public opinion research firm. We're taking a poll to find out what people think about important issues facing them and would like to ask you a few questions. To begin . . .

A. Are you currently 55 years of age or older?

Yes (CONTINUE) 1
No (ASK B) 2

IF "NO" IN QUESTION A, ASK:

B. Is there anyone at home who is?

Yes (CONTINUE) 1
No (THANK AND TERMINATE) . . . 2

Please tell me if you agree strongly, agree somewhat, disagree somewhat, or disagree strongly with each of the following statements about medicine and health. (READ EACH STATEMENT)

	Yes	No
1. Doctors' fees are usually reasonable. (PROMPT: DO YOU AGREE STRONGLY, AGREE SOMEWHAT, DISAGREE SOMEWHAT, OR DISAGREE STRONGLY WITH THIS STATEMENT?)		
Agree/strongly	1 11%	6%
Agree/somewhat	2 30%	24%
Unsure (DON'T READ)	3 18%	10%
Disagree somewhat	4 21%	23%
Disagree strongly	5 21%	38%

Note *indicates less than 1%
Yes indicates respondent did see film
No indicates respondent did not see film

2. People are beginning to lose faith in doctors.	Yes	No
Agree/strongly	1 23%	26%
Agree/somewhat	2 30%	30%
Unsure (DON'T READ)	3 9%	5%
Disagree somewhat	4 21%	21%
Disagree strongly	5 18%	18%

3. Doctors are too interested in making money.		
Agree/strongly	1 25%	43%
Agree/somewhat	2 34%	26%
Unsure (DON'T READ)	3 9%	7%
Disagree somewhat	4 23%	16%
Disagree strongly	5 9%	9%

4. There is a growing crisis with malpractice suits and awards in this country		
Agree/strongly	1 57%	46%
Agree/somewhat	2 25%	24%
Unsure (DON'T READ)	3 9%	20%
Disagree somewhat	4 2%	5%
Disagree strongly	5 7%	5%

5. Doctors don't care about people as much as they used to.

Agree/strongly	1 25%	36%
Agree/somewhat	2 16%	26%
Unsure (DON'T READ)	3 16%	7%
Disagree somewhat	4 23%	20%
Disagree strongly	5 21%	12%

6. The government should provide better health care for the poor and elderly.

Agree/strongly	1 41%	53%
Agree/somewhat	2 23%	20%
Unsure (DON'T READ)	3 14%	6%
Disagree somewhat	4 18%	11%
Disagree strongly	5 5%	10%

7. Most people become doctors because they want to help other people.

Agree/strongly	1 30%	24%
Agree/somewhat	2 32%	28%
Unsure (DON'T READ)	3 14%	14%
Disagree somewhat	4 18%	16%
Disagree strongly	5 7%	18%

8. Most doctors spend enough time with their patients.

Agree/strongly	1 14%	12%
Agree/somewhat	2 18%	24%
Unsure (DON'T READ)	3 11%	5%
Disagree somewhat	4 39%	23%
Disagree strongly	5 18%	37%

9. Doctors make too much money.

Agree/strongly	1 21%	42%
Agree/somewhat	2 34%	21%
Unsure (DON'T READ)	3 16%	15%
Disagree somewhat	4 25%	18%
Disagree strongly	5 5%	5%

10. Doctors don't make any more mistakes now than they did 10 years ago.

Agree/strongly	1 30%	25%
Agree/somewhat	2 36%	28%
Unsure (DON'T READ)	3 18%	18%
Disagree somewhat	4 5%	9%
Disagree strongly	5 11%	20%

11. Doctors are leaving medical practice because they can't afford the cost of malpractice insurance.

Agree/strongly	1 34%	34%
Agree/somewhat	2 36%	29%
Unsure (DON'T READ)	3 14%	21%
Disagree somewhat	4 11%	9%
Disagree strongly	5 5%	7%

12. Cuts in federal spending on health care are causing some small rural hospitals to close.

Agree/strongly	1 71%	52%
Agree/somewhat	2 11%	21%
Unsure (DON'T READ)	3 9%	16%
Disagree somewhat	4 9%	7%
Disagree strongly	5 —	4%

13. Doctors are fighting to keep the quality of medical care high while government keeps cutting back on what they will pay.

Agree/strongly	1 36%	39%
Agree/somewhat	2 34%	27%
Unsure (DON'T READ)	3 16%	16%
Disagree somewhat	4 7%	12%
Disagree strongly	5 7%	7%

14. Do you think we as a society, are spending too much money, not enough money, or about the right amount of money on health care?

Too much	1 32%	33%
Not enough	2 30%	26%
Right amount	3 23%	29%
Unsure (DO NOT READ)	4 16%	13%

15. Does every American regardless of income or age deserve the best medical care currently available?

Yes	1	77%	92%
Unsure (DON'T READ)	2	11%	3%
No	3	11%	6%

16. Some people say problems in health care are mainly caused by growing numbers of the poor and elderly who want the best medical care available.

Other people say these problems are mainly caused by doctors and hospitals that charge too much money.

Please tell me which statement is closer to your opinion.

Poor and elderly	1	18%	19%
Unsure (DO NOT READ)	2	25%	15%
Doctors and hospitals	3	57%	66%
Don't know/no answer	4	—	1%

17. Did you happen to watch the program about health care at 7:00 p.m. on OETA last night called "Preserving Tradition, Embracing Change"?

Yes (TO 18-22)	1	17%
No (TO 23)	2	83%

IF "YES" IN QUESTION 17, ASK:

18. What do you remember most about that program? (PROBE: PLEASE TELL ME MORE ABOUT THAT)

01. **JUSTIFICATION FOR HIGHER COSTS** — quality of medical care has improved, therefore cost has gone up/doctors' fees and new equipment . . . is what is making the health care go up/purpose was to justify doctors' expensive rates — expensive equipment one reason/ 11%
02. **MEDICARE/ELDERLY** — Medicare and the care of the older people/an effort to present the problem of Medicare as to why people are having to pay more/so many elderly people under the doctor's care and we need money to pay for this care/ 9%
03. **PASSING THE BUCK** — doctor oriented — they put it on and it seemed they are blaming the government and they both are at fault/doctors and hospitals are alibiing and passing the buck/it seemed to be blaming the public for the increase of health care/ 7%
04. **MAKE CHOICE/DENY CARE** — we are going to have to make a choice as to who gets health care/some elderly and children will be turned away/British statement — we need to cut back if people are too old — can't help everybody/ 7%
05. **HORSE AND BUGGY** — the horse and buggy was interesting/the doctor in the horse and buggy/ 5%

06. **IN THE PAST** — about back in the past — how they did things then/they said that doctors called on patients and I think that's a myth/ 5%

07. **CHANGE IN CARE/MEDICINE** — talked about the different changes in health care/something in the change of medicine used/ 5%

08. **POSSIBLE GOVERNMENT CUTS** — possibility that the government will cut a great deal/a lot of old folks may have to go without help . . . if they don't have enough government assistance/ 5%

09. **SMALL HOSPITALS CLOSING** — how the small hospitals are having to close in rural areas/smaller hospitals in rural areas were having problems/ 7%

10. **DOCTORS CONCERNED** — I thought the doctors were very caring for people/the doctors were so concerned/doctors and hospitals are providing what they can with what they have/ 7%

11. **REMEMBER DOCTOR** — I remember the doctor who was on the hour program/I liked Dr. Rosenfeld and his opinions/ 5%

12. **ALL OTHER RESPONSES** — the idea that people are hurting themselves by all these lawsuits against doctors/doctor saying that our purpose and ethics should not change/I am strongly in favor of education about preventive medicine/ 7%

13. **NOTHING MUCH/DON'T REMEMBER** 9%

14. **OTHER** 2%

15. **DON'T KNOW/NO ANSWER** 11%

IF "YES" IN QUESTION 17, ASK:

19. In general, how would you rate that program? Would you say it was — excellent, good, only fair, or poor?

Excellent	1	52%
Good	2	23%
Only fair	3	14%
Poor	4	—
Don't know/no answer	5	11%

IF "YES" IN QUESTION 17, ASK:

20. Thinking about the way the program presented the problems currently facing health care, would you say the presentation of problems was balanced and fair or slanted and biased?

Balanced and fair	1	66%
Unsure (DO NOT READ)	2	11%
Slanted and biased	3	18%
Don't know/no answer	4	5%

IF "YES" IN QUESTION 17, ASK:

21. How effective do you think the program was in educating people about what's really going on in the health care system today — very effective, somewhat effective, not very effective, or not at all effective?

Very effective	1	41%
Somewhat effective	2	39%
Not very effective	3	9%
Not at all effective	4	5%
Unsure (DO NOT READ)	5	2%
Don't know/no answer	6	5%

IF "YES" IN QUESTION 17, ASK:

22. If it were to be shown again, would you recommend the program to friends and neighbors?

Yes	1	82%
Unsure (DO NOT READ)	2	2%
No	3	9%
Don't know/no answer	4	7%



Paul L. Patton (right), executive director of the Tulsa County Medical Society, confers with fellow Tulsan Robert M. Gold, MD, during a reference committee meeting.

PROFESSIONAL AND PUBLIC RELATIONS

Now, just one final question for statistical purposes only —

23. What is the last grade you completed in school?

(DO NOT READ, JUST RECORD)

Some grade school (1-8)	1	
Some high school (9-11)	1	14%
Graduated high school (12)	2	30%
Technical/vocational (12)	2	
Some college (13-15)	3	9%
Graduated college (16)	4	
Graduate/professional school (16 or more)	4	43%
Don't know/no answer	5	5%

SELECTED VERBATIM RESPONSES

Question 18:

Did you happen to watch program about health care at 7:00 p.m. on OETA last night called "Preserving Tradition, Embracing Change"? What do you remember about that program?

Education: Some college

The program was filmed here in Tulsa. A doctor was saying that our purpose and ethics should not change and that doctors are here to heal people and treat people. The medical profession should try and save people. It worked too much on emotion — little on facts.

Education: College graduate

The idea that people are hurting themselves by all those lawsuits against doctors. Doctors are having to pay higher insurance rates because of all the lawsuits. As a result of these lawsuits, doctors are having to raise their prices to pay for this high insurance.

Education: College graduate

The doctors were so concerned about not being able to help the patients. I think they are interested in keeping everyone well. They are worried about not being able to continue research if they don't have enough money.

Education: Some high school

The possibility that the government will cut a great deal. I have friends who can't go to the doctors because the government won't take care of it. They throw elderly patients out of hospitals if they are on Medicare to make room for paying patients. This lady I know does not have enough insurance. She doesn't get much Social Security and if you have Medicare, the doctors don't treat you as well as they do if you paid for care.

Education: College graduate

The overall cost of our medical services — compared to what it used to be. The advancements in technology and equipment have made prices rise so rapidly.

Education: Some high school

It talked about the different changes in health care and how it affects people. Years ago, you paid a single payment and you stayed in the hospital until you were well. Now you pay a certain amount of money and are given a certain amount of time. You must leave the hospital when your time is up if you are well or not. You must also pay one amount. If the cost is less, you still pay the full amount. Health care units try to send you home sooner so they can make more money.

Education: Less than high school

The doctors in the horse and buggy. A young lady took her sick child to the emergency room instead of her doctor's office. It was closed. She made the statement at the emergency room that, "It's all right that the doctor wasn't in today. I have Medicaid and it will pay for this bill."

Education: College graduate

The part that frightened me was some elderly people and children will be turned away and not given any care. The elderly person with a hip misplaced and they're too old or a child who is a borderline case. It's sad.

Education: Some college

More or less doctor-oriented. They put it on and it sounded like they are blaming the government and they both are at fault. The poor and elderly are being used as pawns. It's unfair and we don't know how to stop it.

Education: College graduate

They — doctors and hospitals — are alibiing and passing the buck. Technically we are advanced and our high technology has made it possible for people to live longer than they would have 20 years ago with the same illnesses. It's the curse of our times! We have the equipment and technical knowledge today, but we are not able to pay for it.

Education: College graduate

The fact that there are so many elderly people under doctors' care and we paid money to pay for this care. People are living so much longer these days and much more is spent on medical services.

Education: College graduate

I remember it as an effort to present the problem of Medicare as why people are having to pay more. They showed that with the overuse of Medicare, adjustments had to be made somewhere. Reductions have to be made somewhere along the line.

Education: Some high school

How the small hospitals are having to close in the rural areas. People do not have enough money to pay the required fees and the government has cut back on what it pays.



Perry A. Lambird, MD, and Warren M. Crosby, MD, of Oklahoma City study their delegate handbooks.

Report of the COUNCIL ON PUBLIC AND MENTAL HEALTH

Subject: Annual Report

Presented by: Robert M. Mahaffey, MD, Chairman

Referred to: Reference Committee II

Introduction

It is the goal of the Council on Public and Mental Health to provide the citizens of the State, as well as OSMA members, with timely information regarding the medical aspects of public health and to conduct and oversee needed programs in these areas.

Review of Activities

The Council remains one of the OSMA's most active. After many years of distinguished service, George W. Prothro, MD, Tulsa, stepped down as the Council's Chairman. The OSMA is grateful for Doctor Prothro's past work and is very pleased that he will remain a member of the Council.

The Council was very active again this year in the support of perinatal care in Oklahoma.

The Council voted to recharge the OSMA Perinatal Task Force. Mary Anne McCaffree, MD, OKC, agreed to serve as Chair of the Task Force.

The Perinatal Task Force met several times during the year. The Council endorsed Perinatal Task Force recommendations that the Governor's Task Force on Perinatal Care be continued during the Bellmon Administration.

The OSMA has been in contact with representatives of the Governor's office who are receptive to the idea of continuing the Governor's Task Force.

The Council also approved a Perinatal Task Force recommendation that the OSMA take the initiative and explore with representatives of the Oklahoma Hospital Association, Oklahoma Nurses Association, and the Oklahoma Osteopathic Association, the feasibility of establishing a comprehensive, statewide perinatal education program.

The Council urges PLICO to develop, where possible, specialty-specific loss prevention seminars.

The Council this year also appointed an Ad Hoc Committee on A.I.D.S. Physicians who have agreed to serve on the Committee are Jeff Beal, MD, Tulsa; Douglas P. Fine, MD, OKC; George W. Prothro, MD, Tulsa; Lloyd W. Owens, MD, OKC; Jennifer Johnson, MD, OKC; Donald Cooper, MD, Stillwater; Greg Istre, MD, OKC; Philip J. Rettig, MD, OKC; Ronald O. Gilcher, MD, OKC; Eric L. Westerman, MD, Tulsa; and Jodie Edge, MD, Norman.

In addition, the Council continues to interface with the Oklahoma Department of Health and Mental Health and the Physician Manpower Training Commission.

The Council's Maternal Mortality Committee continues to function on an as-needed basis as does the Sports Medicine Committee.

Objectives

- 1) Continue support for the Perinatal Task Force.
- 2) Establish goals and objectives for the Ad Hoc Committee on A.I.D.S.
- 3) Continue to interface with Oklahoma State Health and Mental Health Departments.

Budget Requests

Council Expenses	\$ 500.00
Committees (Perinatal, A.I.D.S., Maternal Mortality)	700.00
TOTAL	\$1,200.00

Respectfully submitted,
Robert M. Mahaffey, MD,
Chairman

Edgar M. Cleaver, MD
Gordon H. Deckert, MD
Sara R. DePersio, MD
Hayden H. Donahue, MD
John W. Drake, MD
Jodie L. Edge, MD
George B. Gathers, MD
William G. Harvey, MD
Roger B. Hensley, MD
Jerry R. Hordinsky, MD

Gregory Istre, MD
Joe B. Jarman, Jr., MD
Bertha M. Levy, MD
John S. Muchmore, MD
Jerry R. Nida, MD
Edward K. Norfleet, MD
George W. Prothro, MD
Ralph W. Richter, MD
Hal B. Vorse, MD
MS Rochelle Ablah
MS Robert Ricketson
Mike Sulzycki, OSMA

Report of the COUNCIL ON MEDICAL EDUCATION

Subject: Annual Report

Presented by: Irwin H. Brown, MD, Chairman
Referred to: Reference Committee II

Introduction

The Council shall study and make recommendations related to all matters of maintaining or improving the level of competency of physicians in Oklahoma, including but not limited to, maintaining liaison with the medical education colleges in Oklahoma, to conducting continuing medical education courses for association members, and to the resurveying of medical education programs in Oklahoma. It will also monitor continuing medical education standards as they may be required by association policy.

Activities

The following institutions were resurveyed by the Council during the 1986/1987 period:

Baptist Medical Center, Oklahoma City
*Duncan Regional Hospital, Duncan
Mercy Health Center, Oklahoma City
South Community Hospital, Oklahoma City

The following institutions have requested information on accreditation during the 1986/1987 period:

Community Hospital, Elk City
Deaconess Hospital, Oklahoma City
Great Plains Hospital, Lawton
HSA Meadowlake Hospital, Enid
Norman Regional Hospital, Norman

Physicians Manpower Study—Throughout 1986/1987, the Council on Medical Education has reviewed and made comment on the Oklahoma State Regents For Higher Education Physician Manpower report. The Council intends to monitor all activity in this regard and report its findings to the OSMA when appropriate. In addition, the Advisory Committee on Physician Manpower and Medical Education will be monitored and its findings will also be reported.

Recommendations

1. The OSMA continue its support of open communication with the Oklahoma medical schools, and encourage medical students to become more involved in organized medicine.

2. The OSMA actively encourage hospitals and other medical organizations to become accredited to produce continuing medical education programs for the state of Oklahoma.

3. The Council will continue to send representation to local, state, and national education meetings when appropriate.

4. OSMA representatives participate in national accrediting surveys when asked by the Accreditation Council on Continuing Medical Education.

*Resurvey was not completed at time of this report.

Budget Request: \$500.00

Due to an increase in the Council's resurvey fee in 1986, the Council on Medical Education's budget request has been reduced by 50%.

Respectfully submitted,
 Irwin H. Brown, MD, Chairman
 John R. Alexander, MD
 Robert C. Bowman, MD
 Robert T. Buchanan, MD
 Daniel Cogan, EdD
 Donald G. Kassebaum, MD
 Robert W. King, Jr., MD
 Steven Landgarten, MD
 Thomas N. Lynn, Jr., MD
 Richard E. McDowell, MD
 Harris J. Moreland, MD
 Tim K. Smalley, MD
 Edward J. Tomsovic, MD
 Lesley L. Walls, MD
 Edgar W. Young, Jr., MD
 Lorrie B. Hayes, MS III
 Philip Perdue, MS III
 Robert W. Baker III, OSMA Staff

Addendum to the Council on Medical Education Recommendations approved by the OSMA House of Delegates for 1987

Reference Committee II (and the House of Delegates) recommends that the Council on Medical Education:

- 1) Continue to encourage the higher regents to make definitive decisions concerning admissions to all Oklahoma medical colleges;
- 2) Work closely with the University of Oklahoma College of Medicine officials to ensure that there is a proper balance of ~~clinical~~ faculty and practicing physicians represented on the OU College of Medicine's Board of Admissions that will ensure that students admitted to medical school meet appropriate academic standards and meet the medical needs of Oklahoma patients; and
- 3) Present testimony to the Legislature and proper education officials supporting a change from a capitation-based funding system to a program-based funding system for medical education.

Report of the COUNCIL ON MEDICAL SERVICES

Subject: Annual Report

Presented by: Ronald S. Barlow, MD, Chairman

Referred to: Reference Committee II

Introduction

The Council has been charged with the duties of studying and making decisions and formulating activities with respect to provisions of accurate medical care, including but not limited to the design and evaluation of all types of health care delivery systems, health planning, the financing of medical services and its impact on the quality of patient care, the social aspects of health, internal peer review mechanism, and the appraisal of all external programs which affect the cost and quality of medical care.

Review of Activities

The Council meets as needed to conduct appropriateness reviews and fee reviews.

A. Appropriateness Review — The Council continues to review cases that deal with the appropriateness and quality of care. The creation of the OSMA Committee on Ethics and Clinical Competency has taken much of the burden of the Committee on quality of care issues. One case has formally been adjudicated and several are still under consideration.

B. Fee Reviews — The Council also conducts fee reviews. Two reviews have been completed with several still in process.

Numerous complaints regarding both fees and quality of care are handled on an informal basis by staff under the direction of the Council.

C. Vendor Drug Program — This Committee, which consists of representatives of the OSMA, the Oklahoma Pharmaceutical Association, and the Oklahoma Osteopathic Association serves at the request of the Department of Human Services to advise the Department as to efficacious allocation of prescription medications to Medicaid patients.

Due to the state's current economic condition, this Committee's work has become more important and more difficult. The Committee met three times this year at the request of the Department.

OSMA members on the Committee are: James D. Funnell, MD, and Jerry B. Vannatta, MD. The late Edgar W. Young, MD, served on the Committee for many years. Thomas L. Whitsett, MD, also serves on the Committee.

Objectives

- 1) Continue appropriateness of care activities.
- 2) Continue fee review activities.
- 3) Study and make recommendations when necessary on health care delivery and financing issues.



Dr and Mrs Elvin M. Amen, Bartlesville, share a quiet moment Saturday evening. Dr Amen was OSMA president in 1985-86.

Budget Request

Council Meeting Expenses	\$500.00
TOTAL	\$500.00

Respectfully submitted,
 Ronald S. Barlow, MD
 John A. Blaschke, MD
 Donald L. Cooper, MD
 Kurt Frantz, MD
 Jay A. Gregory, MD
 Bartis M. Kent, MD
 Gretchen A. McCoy, MD
 Ray V. McIntyre, MD
 John R. Perkins, MD
 Ed E. Rice, MD
 David J. Shepherd, Jr., MD
 MS Richard Fellrath, Jr.
 MS Jeff Reames
 Mike Sulzycki, OSMA

Report of the OKLAHOMA STATE MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Subject: Annual Report

Presented by: Lloyd Biby, MS IV, Oklahoma City
 Referred to: Reference Committee II

Introduction

The OSMA Medical Student Section is comprised of medical students from the University of Oklahoma College of Medicine, the University of Oklahoma Tulsa Medical College, and Oral Roberts University School of Medicine. The purpose of the section is to introduce students to organized medicine and the issues that affect the practice of medicine.

Review of Activities

This was truly a year of transition for the OSMA Medical Student Section.

The Section owes much of its success to Wilson D. Steen, PhD, professor emeritus of the OU College of Medicine, who nurtured the Section's growth over the past decade. With Doctor Steen's retirement, the Student Section lost a friend and leader.

Nevertheless, OSMA medical student membership is at an all-time high — some 350 members.

Locally, OSMA sponsored picnics to welcome medical students both to school and organized medicine.

Ongoing Luncheon Roundtables allow medical students to visit with practicing physicians and discuss topics from how to start a practice to medical ethics.

OSMA medical student members are active participants on councils and elected delegates to represent Oklahoma at national medical student meetings.

Objectives

- 1) Continue Annual Picnics.
- 2) Continue Roundtable Discussion Program.
- 3) Establish seminars for third and fourth year students.
- 4) Study ways to increase communication between Tulsa and OKC students.
- 5) Represent Oklahoma medical students at national AMA meetings.

Fiscal Note: \$8,500.00

Report of the JOURNAL OF THE OKLAHOMA STATE MEDICAL ASSOCIATION

An Addendum to the Report of the
 Council on Professional and Public Relations

Subject: Annual Report

Presented by: Mark R. Johnson, MD, Editor-in-Chief
 Referred to: Reference Committee II

Introduction

The JOURNAL of the Oklahoma State Medical Association has maintained its position as one of the nation's finest medical publications by providing its readers with timely, significant scientific articles and special feature stories. The JOURNAL remains a very popular and important benefit of membership in the association.

Review of Activities

In May 1986, Robert G. Tompkins, MD, Tulsa, resigned his position on the JOURNAL's Editorial Board. He had been a board member since August 1968. Donald L. Brawner, MD, was appointed to fill the position.

In March of this year, the JOURNAL received word that it had won first prize in the state medical journal category



The sign on the door says Board Room, but to OSMA staff members it's the Annual Meeting office. Here Debbie Hinson, Ed Kelsay's secretary, works on one of many reports generated during the meeting.

of the Sandoz Pharmaceuticals medical journalism awards competition. This marks the second time in the twelve-year history of the nationwide competition that the JOURNAL has received top honors, the first being in 1978. An honorable mention was earned in 1983.

Judges praised the JOURNAL's new format, introduced in 1986, and called the publication "very, very well done" and an "altogether first-rate job." Sandoz said the JOURNAL "has been excellent for many years; now it's even better." A Sandoz representative will present the \$500 prize and certificate during the Opening Session of the OSMA House of Delegates at this year's Annual Meeting.

The very popular Leaders in Medicine series will continue to be a feature in selected issues of the JOURNAL. The articles will focus on Oklahoma physicians who have made significant contributions to Oklahoma medicine and who, in the opinion of the Editorial Board, deserve to be recognized for their accomplishments. Featured during the last year were George Richard Russell, MD, (November 1986) and Richard E. Carpenter, MD (March 1987).

The Editorial Board, at its annual meeting on April 7, selected the winner of the \$500 Charlotte S. Leebron Memorial Trust Award, given annually to the author(s) of the best scientific paper published in the JOURNAL the preceding year. The award for 1986 will go to Samuel Sepkowitz, MD, for his paper "Improvement in the Birth Weight Distribution Among White Newborns in a Community Hospital," which appeared in the May 1986 issue. The award is presented at the OSMA's Annual Meeting each May.

Respectfully submitted,
Mark R. Johnson, MD, Editor-in-Chief
Harris D. Riley, Jr., MD, Editor
Donald L. Brawner, MD, Editor
Susan R. Harrison, Managing Editor

Reference Committee III

REPORTS TO THE HOUSE OF DELEGATES



Determination shows in the face of Garry Pohoretsky, MD, Oklahoma City, new vice-chairman of the Young Physicians Section. This year's meeting officially launched the new section, established to address the problems and concerns of the OSMA's younger doctors.

Report of REFERENCE COMMITTEE III

Presented by: William C. Stone, MD, Chairman

Mr Speaker and Members of the House of Delegates:

Reference Committee III gave careful consideration to the several items referred to it and submits the following report:

(1) Report of the Council on Governmental Activities
Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the Council on Governmental Activities be adopted.

Reference Committee III heard a council report summary from Perry A. Lambird, MD, Council Chairman. Dr Lambird mentioned to the Committee that the OSMA's federal legislative efforts have met with great success throughout the past year. Dr Lambird noted that the concurrent resolutions relating to the opposition of DRGs for RAPs, as well as the opposition to mandatory assignment, have been successfully cosponsored by six of our eight-member Congressional Delegation. Dr Lambird expressed his appreciation to the OSMA staff, to our Washington liaison, John Montgomery, and to the entire Council for their dedication.

(2) Report of the Council on State Legislation
Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the Council on State Legislation be adopted.

Reference Committee III heard from Ms Otie Ann Carr regarding the Council on State Legislation's report. Ms Carr stressed that although the legislative session is near completion, numerous legislative items, specifically appropriation bills, are yet to be passed by the legislature. This Reference Committee recognizes the efforts of the OSMA membership and especially the efforts and dedication demonstrated by the OSMA Auxiliary. The Council on State Legislation should be commended for their continued support towards the passage of meaningful tort reform. This Committee is optimistic that tort reform will be achieved with the continued participation of the OSMA/OSMAA membership.

(3) *Report of the Council on Member Services*

Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the Council on Member Services be adopted.

Reference Committee III wishes to congratulate William O. Coleman, MD, for his dedication to the numerous responsibilities charged to the Council on Member Services.

(4) *Report of the Oklahoma Medical Political Action Committee*

Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the Oklahoma Medical Political Action Committee be filed.

Reference Committee III was very encouraged by the increase in the membership figures of OMPAC for 1986/1987. The Committee wishes to commend the dedication of Larry L. Long, MD, Robert W. Baker, and Ann McWatters for their devotion in an area that will undoubtedly benefit every legislative association activity. The Committee commends the OMPAC Board of Directors for their 90% winning percentage during the 1986 General Election and would like to urge every OSMA member, auxilian, resident, and student to continue their support of this all-important committee.

(5) *Report of the Physician Recovery Committee*

Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the Physician Recovery Committee be adopted as amended.

Reference Committee III commends the work of the Physician Recovery Committee and especially the devotion exhibited by J. Darrel Smith, MD. The Committee recommends that the report be amended on page 2, line 5, by adding the word *assistant* following the letters *PRC*. This amendment more accurately addresses the OSMA Board of Trustees' action taken, which created an assistant medical director for Eastern Oklahoma.

(6) *Resolution 7 — Waiver of Dues for Political Office Holders*

Recommendation:

Mr Speaker, your Reference Committee recommends that Resolution 7 be adopted.

The Committee concurs with the Tulsa and Oklahoma County medical societies in their belief that the association should make every effort to encourage physician members to hold elective office at the federal, state, or executive branch of our government. The Committee believes that the time and effort that must be expended not only to run for political office but to hold that office deserves the association's appreciation. The Committee believes that



This figure was one of many items up for bid in the AMA-ERF Silent Auction, conducted in the Auxiliary's Hospitality Room. Items for the auction are made and donated by OSMA Auxiliary members as part of their annual fund-raising activities.

the adoption of this resolution will help to further encourage those members to come to the aid of the medical profession through elective office. The Committee applauds this resolution and urges its adoption.

(7) *Resolution 8 — Opposition to Closing the College of Dentistry*

Recommendation:

The Reference Committee heard support of this resolution by John Blaschke, MD, and Mr Rick Ernest, Executive Director of the Oklahoma County Medical Society, others testifying, and members of the Reference Committee concur with the resolution to support continuation of the dental school. It is the consensus of the Reference

Committee that, while Oklahoma has economic problems and we are in a period of lean times, this health-related institution is important to the future of Oklahoma. Therefore, your Reference Committee recommends the adoption of the following substitute resolution 8:

"Resolved, that the College of Dentistry of the University of Oklahoma Health Sciences Center is an integral part of the health sciences of the State of Oklahoma and contributes significantly to the health care of the Oklahoma citizenry.

"Resolved, That the Oklahoma State Medical Association House of Delegates formally oppose the proposed plan to close the College of Dentistry as a cost-saving measure; and be it further

"Resolved, That a copy of this resolution be forwarded to the office of the Governor of the State of Oklahoma, the President of the University of Oklahoma, the Provost of the University of Oklahoma Health Sciences Center, the Dean of the College of Dentistry and the Oklahoma Dental Association.

The Committee's amendments are grammatical in nature and in no way diminish the true concept of the original resolution.

Mr Speaker, Reference Committee III recommends adoption of this report as a whole as amended.

Mr Speaker, this concludes the report of Reference Committee III. Your Reference Committee wishes to thank all who participated in the hearing and contributed to the preparation of this report. As chairman of this Reference Committee, I would like to express my appreciation to the committee members and staff for their time and effort.

Respectfully submitted,
William C. Stone, MD, Tulsa, Chairman
Marvin D. Peyton, MD, Oklahoma City
Jimmie K. Jackson, MD, Oklahoma City
Walter H. Gary, MD, Tulsa
Theodore J. Brickner, Jr., MD, Tulsa
Thomas E. Rhea, MD, Idabel
Philip C. Bryan, MD, Miami
Robert W. Baker, III, Staff
Ann McWatters, Staff

Report of the COUNCIL ON GOVERNMENTAL ACTIVITIES

Subject: **Annual Meeting Report**
Presented by: Perry A. Lambird, MD, Chairman
Referred to: Reference Committee III

Introduction

The Council shall review federal legislation and regulation of concern to the medical profession or the public health, and shall initiate activities or undertake

appropriate responses on matters of priority interest. It shall also establish and maintain relations with federal government entities having statutory or regulatory jurisdiction affecting the medical profession, the delivery of health care, or the public health. In cooperation with other association councils and committees, it shall develop policy recommendations for consideration by the Board of Trustees, and it shall prepare testimony and otherwise conduct the federal legislative program of the association.

Washington Activities

The Reagan Administration, in its fiscal year 1988 budget, has called for inclusion of the services of radiologists, anesthesiologists, and pathologists in hospital Diagnosis Related Group (DRG) payments. The OSMA, in conjunction with the AMA, has undertaken an all out effort to fight the inclusion of ANY physician services in the DRG system. The strategy throughout this congressional session has been to garner a show of political strength via cosponsorship of senate and house concurrent resolutions aimed at fighting DRGs.

SCR 15 and HCR 30 make three specific points:

1. As a result of the DRG reimbursement system for inpatient hospital services under Medicare, there are serious concerns about the quality of care available to Medicare beneficiaries. In fact, the General Accounting Office has reported to the Congress that Medicare beneficiaries are being discharged from hospitals sicker and quicker.

2. DRGs do not have the support of Congress, indicating that the administration has once again gone a step too far in shaping policy through the budget process. Although savings from DRGs are only speculative, health economists warn that physician DRGs could hurt access and quality. More importantly, the Congress has indicated in the last two reconciliation bills that the relative value scale, RVS, being developed by Harvard is its preferred reform approach.

3. Finally, the implementation of such a reimbursement system, even if only for hospital-based physicians, would in all likelihood necessitate the incorporation of mandatory acceptance of assignment of Medicare benefits which would result in the distribution of services and compensation.

On behalf of the OSMA, the Council of Governmental Activities has contacted each member of the Oklahoma Congressional Delegation and asked their assistance in cosponsoring either SCR 15 or HCR 30. An additional effort was made, when the OSMA sent a delegation to Washington to meet with each congressman in an effort to gain cosponsorship. We are pleased to report that our efforts have garnered six out of eight congressmen to the concurrent resolutions. Congressmen English, McCurdy, Inhofe, Edwards, and Watkins, and Senator Nickles have all agreed to cosponsor our concurrent resolutions.

Campaign Finance Reform

Fulfilling his vow to "raise the PAC issue again and again" until reform is achieved, Senator David Boren has introduced one of the first bills of the new 100th Congress. The new bill, legislation to place spending limits on and inject public financing into senate elections, encompasses points found in last year's Boren proposal but also widens the scope to finance senate election campaigns at taxpayers' expense. Seven democratic senators, including Majority Leader Robert Byrd and Edward Kennedy, have joined Boren in sponsoring the legislation.

Professional Liability Reform

While over two-thirds of the states enacted some measure of tort reform during 1986, the professional liability crisis continues unabated. The Congress considered several proposals offering relief of varying degrees this past year. Congressman John Porter (R-Illinois) has already signaled that he is willing to introduce legislation providing incentives to the states to enact specific tort reform measures. Congressmen Don Ritter (R-Pennsylvania) and Hamilton Fish (R-New York) have shown interest in using a "disincentive" approach to require state action. The OSMA and the AMA will actively urge the 100th Congress to adopt legislation establishing financial incentives to encourage states to adopt a set of minimum tort reforms. The Oklahoma Congressional Delegation has been informed of our difficulties in the state legislature.

AMA's Tobacco Advertising Ban Bill

On Wednesday, February 18, 1987, following a Washington, DC, press conference, the AMA's Tobacco Advertising Ban bill was reintroduced by Congressman Mike Synar. The legislation introduced by Synar last year in the 99th Congress gained 25 cosponsors, but a heavy agenda diminished the possibility of moving the bill in its final session. The House Energy and Commerce Committee will once again have jurisdiction over this legislation.

Selective Service Legislation

The Office of Management and Budget is reviewing Selective Service legislation that would facilitate registration and induction of health professionals in the event that national mobilization was ordered by the President. The bill under study is similar to the one that was introduced in the last Congress by Representative Sonny Montgomery of Mississippi. While the draft bill, on the surface, seemingly is innocuous, the AMA and OSMA are concerned that it could lead to a registration system for health professionals. The AMA has urged that selective service rely on private sector groups in developing manpower contingency plans in the event there should be a national emergency. The AMA had previously responded by offering the Department of Defense authorization to use its physician master file in the event of a national emergency.

Recommendations

The Council on Governmental Activities, in its quest to build greater communication with our congressional delegation, has asked staff to review various means available of communicating the OSMA's position, membership wide, on various congressional legislation and actions. The Council believes that while it is necessary and appropriate for Oklahoma's congressmen to hear from the OSMA, it is specifically advantageous for individual physicians to write letters and send telegrams as well as make personal telephone calls to our Washington delegation. It is the Council's belief that these individual physician efforts will increase the overall visibility of Oklahoma physicians with our congressional delegation. Presently, staff is reviewing a number of strategies to increase the individual OSMA physician's access to our congressional delegation. OSMA staff is reviewing "mass response" techniques such as phone banks, telegrams, and letter writing campaigns. The Council will update the Association as soon as details become available.

Recognizing the importance of patient and public input on health related issues, the Council intends to author a resolution designed to create a "Senior Citizen Advisory Committee to the OSMA" as a means of building greater communication between the OSMA and the various senior citizen entities.

The Council recommends the continuation of the delegation trips to Washington, DC, as a means of communicating with our congressional delegation. The continuation of Mr. John Montgomery as the OSMA Washington liaison is recommended by this Council.

Budget Request: \$27,500.00*

*Includes the salary of John Montgomery

Respectfully submitted,
 Perry A. Lambird, MD, Chairman
 Richard J. Boatsman, MD
 William D. Borkon, MD
 Theodore J. Brickner, Jr., MD
 Ed L. Calhoon, MD
 Charles D. Cook, MD
 Raymond L. Cornelison, Jr., MD
 Jerome M. Dilling, Jr., MD
 Curtis E. Harris, MD
 Mark A. Hayes, MD
 Thomas A. Marberry, MD
 G. Lance Miller, MD
 George M. Pikler, MD
 Christian N. Ramsey, Jr., MD
 Ronald H. White, MD
 Kenneth W. Whittington, MD
 Larry L. Long, MD
 Mr. John Montgomery
 Mrs. Jeannie Drake
 Mrs. Nadine Nickeson
 Mrs. Kelsey Walters
 Mrs. Sherry Strebel
 Mrs. Vaughndean Fuller
 Mrs. Jacque Tomsovic
 Steve Kick, MS IV
 Joe Andrezik, MS IV
 Francis S. Lee, MS IV

Report of the COUNCIL ON STATE LEGISLATION

Subject: **Annual Meeting**

Presented by: Larry L. Long, MD, Chairman

Referred to: Reference Committee III

The first session of the 41st Legislature is still convened at the writing of this report. Over the last few months through the press and media we have become painfully aware of the severe budget problems facing our state. The complexity of the situation has made it impossible to discuss simple solutions, and the more complex these solutions become, the more fearful we are for our own profession and special interests. Never before has the late Senator Long's saying been more true: "Don't tax you, don't tax me, tax that fellow behind the tree."

At the writing of this report it does not appear that professional services will be taxed, nor does it appear that our hospitals will be taxed. The leadership of both houses and the Governor are in the process of negotiating a tax compromise. Most of the lobbyists have been waiting outside of the meetings holding their breath and hoping that what they've been told for their special interests will come true. This all sounds good for the medical profession, but one has to ask, "Who is going to be taxed and from where is the money going to come?"

Attached to this report is a summary of all the legislation introduced this session that relates to the medical profession. The bills are listed under the following categories: Insurance, Workers' Compensation, Board of Medical Examiners, Expanding the Scope of Medical Practice, Mental Health, Indigent Care, Tort Reform, and Drug/Alcohol Abuse. For those bills of interest to you, you may look under the subtitle and find their present status in the legislative process. Remember, though, that appropriation bills are not required to meet any of the legislative deadlines; in other words, they remain alive until the end of session. At this time, however, I would like to make some comments regarding three of the categories: Tort Reform, Indigent Care, and Expanding the Scope of Medical Practice.

Tort reform in the form of SB 134 was unsuccessful this year. It died in the Senate Rules Committee by one vote. Last year the tort bill only had four votes in the Senate Rules Committee. If the bill had passed out of Rules it would have become law because we had enough votes on the Senate Floor and the House Floor to pass the bill. The loss of one vote in the Rules Committee shattered all hopes for significant tort reform. The bills that are still alive are listed for your review, but the bill to watch for the remainder of the session is SB 183. Although it is not a substitute SB 134, it contains some important reforms for the medical profession.

Indigent care is an issue that will be discussed until the end of session. Recognition of this critical problem is reflected in Governor Bellmon's proposed budget and legislative agenda. Basically, the proposal calls for raising state revenue by charging sales tax on health care services,

including hospital services, and dedicating at least part of that revenue to an indigent care fund. The funds are proposed to be retained and distributed to qualifying hospitals by the office of State Finance. As you would imagine, the hospitals in Oklahoma do not feel that they can carry the burden of such a tax load; they have lobbied against this proposal and have worked to seek alternatives to fund indigent care. As an immediate answer, the Oklahoma Hospital Association recommends the following five specific revisions of the Medicaid program:

1. Remove the 30 day per year limitation.
2. Increase financial eligibility standards for pregnant women and newborns.
3. Broaden Medicaid coverage to include unemployed parents.
4. Modify Medicaid hospital payment system to adjust for indigent care costs.
5. Convert state-funded OTH subsidy to federally matched Medicaid payments.

If additional state funds were utilized to expand the Medicaid program for additional hospital revenue, each state dollar would produce an additional one dollar and sixty cents federal funds (at the projected federal matching rate of approximately 60%). The advantage of extending the available state funds with federal earnings is obvious.

In terms of Expanding the Scope of Medical Practice, many of you have been concerned about the outcome of SB 39, the Physician Dispensing Bill. We were fortunate to have this bill assigned to a Senate committee whose Chairman, Senator Brown, sided with the physicians' position regarding dispensing privileges. Equally important was the Senate author of the bill, Senator Hooper, who basically said he wanted a bill that the physicians could support. These two individuals forced the pharmacists to work a compromise bill that the medical community could support. The compromise generally covers the following:

1. If a physician dispenses, he or she must register with the Board of Medical Examiners.
2. The Board will write the rules and regulations determining if a physician may dispense drugs and how he or she may dispense these drugs. That determination will be based on whether it is in the best interest of the patient.

Finally, I do not want to close without taking time to thank you for all the help you have given your profession through your involvement in the political process. Those of you who participated in Medicine Day at the State Capitol experienced firsthand the progress we have made over the last few years. It's exciting, and we have just begun. We realize how difficult it is for you to maintain your practice and take the time to be knowledgeable about legislative issues; yet, many of you have recognized the fact that you can no longer afford to not be involved and have arranged your schedule to help yourself by protecting medicine through the legislative process. We hope the Council on State Legislation has assisted you and made that endeavor easier and more productive.

Budget Request: \$65,000

Respectfully submitted,
 Larry L. Long, MD, Chairman
 William L. Hughes, MD
 Nolen L. Armstrong, MD
 M. Tom Buxton, Jr., MD
 Hugh M. Conner, Jr., MD
 Raymond L. Cornelison, Jr., MD
 Billy D. Dotter, MD
 Robert S. Ellis, MD
 William P. Jolly, MD
 William J. Kruse, MD
 Thomas A. Marberry, MD
 Robert M. Melichar, MD
 Steven A. Mueller, MD
 Gary L. Paddack, MD
 Michael J. Schwartz, MD
 Edgar W. Young, Jr., MD
 Mark R. Johnson, MD
 Perry A. Lambird, MD
 Joan K. Leavitt, MD
 Walter H. Whitcomb, MD
 John W. Bumpus, MD
 Jerry Vannatta, MD
 Stephen Acker, MD
 Donald G. Kassebaum, MD
 George F. Short, Attorney
 Stephen T. Lester, MS IV
 John A. Buie, MS IV
 Samuel Bielgk, MS IV
 Brooke Caldwell, MS IV
 Jeannie Drake, Auxiliary
 Nadine Nickeson, Auxiliary
 Jacque Tomsovic, Auxiliary
 Vaughndean Fuller, Auxiliary
 Kelsey Walters, Auxiliary
 Ellie Idstrom, Auxiliary
 Otie Ann Carr, OSMA Staff

Status of Bills
 April 14, 1987

SB 18
 Brown
Requiring operators and front seat
 passengers of pickup trucks & vans to
 wear safety seat belts.
 OSMA Position: *Support*

Sen. Comm.
 Bus. & Labor
Dormant

SB 24
 Brown
Providing a penalty of \$50 plus court
 costs for persons who allow children
 four or five to ride in a vehicle without
 child passenger restraint system.
 OSMA Position: *Support*

House Comm.
 Public Safety

SB 45
 Ford
Providing for temporary physical
 disability insignias for motor vehicles.
 OSMA Position: *Support*

Signed by the
 Governor

SB 70
 Taliaferro
Prohibiting the transfer of any im-
 pounded pets to any person for experi-
 mentation; making violation of this law a
 misdemeanor punishable by imprisonment
 in the county jail for not more than one year
 or by a fine of not more than \$3,000 or both.
 OSMA Position: *Oppose*

Senate Comm.
 Crim. Juris.
Dormant



At the Inaugural — OSMA Past President James B. Eskridge III and his wife, Margaret. Behind them is Edward K. Norfleet, MD, Vinita.

SB 74
 Cullison

Increasing to 3/4 of 1% with a minimum
 of \$1,500 and a maximum of \$5,000 the ap-
 plication fee accompanying certificates of
 need required by the Okla. Health Plan-
 ning Commission for the establishment of or
 change of services in a long-term care
 facility; increasing to \$5,000 license fees
 for HMOs; increasing to 3/4 of 1%, with a
 minimum of \$1,500 and a maximum of
 \$10,000 the application fee accompanying
 certificates of need required by the com-
 mission for establishment of or change of
 services in a health care facility.

Senate Comm.
 Appropriations

SB 93
 Cullison

Abolishing the Physician Manpower
 Training Commission.

Senate Comm.
 Appropriations
Dormant

SB 129
 McCune

Requiring the State Commissioner of
 Health to establish a tumor registry.

House General
 Order

SB 151
 Smith

Requiring that in paternity proceed-
 ings a person who has been determined to
 be the father of a child may be ordered to
 pay all or part of the costs of birth.

House Comm.
 Human Services

SB 158
 Brown

Removing the requirement that
 municipalities must pay the \$100
 medicolegal autopsy fee to the Office
 of the Chief Medical Examiner when a
 death or injury resulting in death
 occurs within the municipal boundaries.

Senate General
 Order
Dormant

SB 159
 McCune

Authorizing the State Department
 of Health to establish a birth defects
 surveillance program.

House General
 General

SB 197
 Wright

Permitting fulltime employees of
 the Office of the Chief Medical Ex-
 aminer to carry firearms for personal
 protection after an approved course
 of firearm training.

Senate Comm.
 Crim. Juris.
Dormant

SB 299
 Taliaferro

Providing that certain social
 workers not licensed by the state
 shall be licensed within 90 days after
 the passage of this act under specified
 provisions.

House Comm.
 Hum. Services

SB 300
 Cain

Providing that medical examiner
 death certificates will not be required
 in cases investigated solely for the
 purpose of issuing a permit for transport
 of a body out of state.

Amended and
 Passed House
 Returned to
 Senate

SB 327 McCune	Prohibiting smoking in public place not designated as a smoking area. OSMA Position: <i>Support</i>	House Comm. Mental House	HB 1323 Koppel	Directing closure of the Oklahoma College of Osteopathic Medicine and Surgery.	House Comm. Rules <i>Dormant</i>
SJR 19 McCune	Establishing a task force on Alzheimer's disease and related disorders.	House Comm. Mental Health	HB 1332 Riggs	Providing qualifications for directors of city-county health departments.	Passed Senate Hum. Resources
HB 1010 Riggs	Increasing allowable cost for medi- cal records from 10 cents to a maximum of 50 cents per page not including postage if requested by mail. OSMA Position: <i>Support</i>	Senate Comm. Judiciary	HB 1360 Heaton	Encouraging local governments to exer- cise their discretion in adopting a 911 emergency number system.	House Comm. Govt. Oper. <i>Dormant</i>
HB 1014 Cotner	Adding vehicles owned and oper- ated by persons who provide rescue services to the definition of authorized emergency vehicles.	Senate Comm. Transportation	HB 1383 Duckett	Providing certification for certain institutional health services to include transitional living facilities and Halfway houses.	Senate Comm. Hum. Resources
HB 1017 Bastin	Requiring that organ donor information be printed on the reverse side of identification licenses. OSMA Position: <i>Support</i>	Signed by Governor	HB 1396 Lassiter	Authorizing additional fees for Board of Pharmacy examination.	Senate Comm. Bus. & Labor
HB 1020 Cox	Requiring births of children in a con- dition of dependence on controlled dangerous substances be reported to the county office of the Department of Human Services. OSMA Position: <i>Support</i>	Senate Comm. Judiciary	HB 1409 McCorkell	Appointing a representative of the Oklahoma Pediatricians Association to an interagency child abuse prevention task force and removing a representative of the Oklahoma Health Systems Agency.	Senate Comm. Hum. Resources
HB 1035 Riggs	Outlining procedure for requesting consent for organ or tissue donations. OSMA Position: <i>Strongly Support</i>	Passed Senate Hum. Resources	HB 1436 Lassiter	Prohibiting the sale of professional samples of complimentary drugs.	Senate Comm. Bus. & Labor
HB 1060 Heaton	Requiring hospitals to establish protocols for encouraging organ and tissue donations for transplantation purposes. OSMA Position: <i>Support</i>	House Comm. Public Health <i>Dormant</i>	HB 1440 George	Prohibiting the State Department of Health from issuing any permits for the disposal or storage of controlled industrial waste in a landfill with exceptions.	House Comm. Public Health <i>Dormant</i>
HB 1164 Harris, Ken	Prohibiting sheriffs from transporting juveniles unless certified as qualified to perform such duty.	Senate Comm. Judiciary	HB 1460 Anderson	Creating the Group Homes for the Developmentally Disabled or Physically Handicapped Persons Act.	Senate Comm. Hum. Resources
HB 1167 Roberts, Larry	Prohibiting smoking in public school buildings and facilities and in any enclosed, indoor area owned or operated by the state or any political subdivision, which is used by the public, serves as a workplace or is used as a meeting place for a public body.	House Comm. Public Health <i>Dormant</i>	HB 1476 White	Directing that AIDS prevention education be provided to pupils from 5th through 12th grades. OSMA Position: <i>Support</i>	House rejects Senate Amend. Req. Conference
HB 1169 McCorkell	Providing that no directors of nonprofit corporations shall be personally liable to their respective corporations for breach of fiduciary duty; providing exceptions.	Senate Comm. Judiciary	HB 1478 Mentzer	Providing for application qualification of candidates to medical school.	Senate Comm. Bus. & Labor
HB 1170 Anderson	Modifying the definition of deprived child to include children whose parents refuse them medical care because of religious beliefs when permanent physical damage could result and communicable disease and sanitation laws are violated.	House Comm. Human Services <i>Dormant</i>	HJR 1022 Larason	Providing for appointment of a task force to study teenage pregnancy and teenage parenting and appointment of an advisory board.	Amended but Failed 45-50 Held on notice to reconsider <i>Dormant</i>
HB 1189 Cotner	The "Hydration and Nutrition for Incompetent Patients Act"	Senate General Order	Legislation regarding Insurance is listed below:		
HB 1212 Leist	Requiring persons seeking to obtain a marriage license to file a certificate stating that each party has been given a standard screening test to detect the presence of antibodies to the human T-lymphotropic virus type III.	House Comm. Public Health <i>Dormant</i>	SB 147 Stipe	Creating the "Oklahoma State Liability Insurance Fund Act"	Senate Comm. Judiciary <i>Dormant</i>
HB 1223 Leist	Requiring persons convicted of prostitu- tion to be tested for detection of the presence of antibodies to the human T-lymphotropic virus AIDS; providing that any person convicted of engaging in prostitution after testing positive shall be guilty of a felony.	Amended and Passed Senate Returned to House	SB 173 Hooper	Providing that prior carriers of life, accident, or health insurance policies are liable only to the extent of their accrued liabilities and extension of benefits.	Senate Comm. General Order <i>Dormant</i>
HB 1283 Duckett	Authorizing the board of county com- missioners of each county to hire counselors for the purpose of providing counseling to victims of crime.	Senate Comm. Gen. Govt.	SB 202 Roberts	Requiring the state insurance commis- sioner to adopt regulations establishing reasonable standards for rating plans.	Senate Comm. Bus. & Labor <i>Dormant</i>
			SB 203 Roberts	Authorizing the state insurance com- missioner to implement a joint underwriting plan if any type of property or casualty insurance is not adequately available.	House Comm. Insurance
			SB 204 Roberts	Permitting financial institutions to own Oklahoma-licensed reinsurers and participate as underwriting members or investors in certain underwriting members of any insurance exchange.	Senate Comm. Bus. & Labor <i>Dormant</i>
			SB 205 Roberts	Setting conditions for insurers' cancellation of commercial risk, professional liability or public entity insurance policies.	Senate Comm. Bus. & Labor <i>Dormant</i>

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SB 206 Roberts	Requiring the state insurance commissioner to establish annual limitations upon rate increases or decreases taking effect without prior approval.	Senate Comm. Bus. & Labor <i>Dormant</i>
SB 213 Smith	Providing that provisions relating to application of rate restrictions shall not apply to certain types of insurance.	Senate Comm. Bus. & Labor <i>Dormant</i>
SB 249 Roberts	Creating the "Physicians and Surgeons Professional Insurance Merit Rating Plan Act."	Senate Comm. Bus. & Labor <i>Dormant</i>
SB 250 Roberts	Creating the "Commercial Self-Insurance Act"; permitting any person or group to form a commercial self-insurance fund.	Senate Comm. Bus. & Labor <i>Dormant</i>
SB 255 Hooper	Requiring unlicensed health coverage providers to include on the front pages of their policies notices that such policies are not covered by state insurance guaranty funds and that the coverage providers are not subject to jurisdiction of the Oklahoma state insurance commissioner.	House Comm. Insurance
SB 293 Taylor	Creating the "Oklahoma Liability Reinsurance Facility Act."	Senate Comm. Bus. & Labor <i>Dormant</i>
SB 340 Taylor	Providing that insurance rates shall not be subject to unreasonable fluctuation; removing income derived from the investment of unearned premiums and loss reserve fund.	House Comm. Insurance
HB 1005 Holden	Requiring certain insurance companies to file annual reports regarding loss and expense experiences and other data, with the Office of the State Insurance Commissioner.	Senate General Order
HB 1030 Holden	Making certain insurance company records submitted to the insurance commissioner by the National Assoc. of Insurance Commissioners' Insurance Regulatory Information System, confidential records increasing from 45 to 60 days the amount of time in which an insurer is to give notice of acceptance or denial of claim.	Senate Comm. Bus. & Labor
HB 1033 Harris, Ken	Authorizing the state insurance commissioner to regulate deposits of domestic surety insurers qualified to transact bail bond business.	Senate Comm. Bus. & Labor
HB 1056 Lewis	Exempting contracts of the State Employees Group Insurance Board and qualified health maintenance organizations from competitive bidding procedures.	Senate Comm. Appropriations
HB 1059 Abbott	Providing for participation in the Education Employees Group Health, Dental and Life Insurance Act by employees of vocational and technical school districts and the Oklahoma State System of Higher Education.	House Comm. Retirement <i>Dormant</i>
HB 1225 Holden	Authorizing the insurance commissioner to employ examiners to insure that the rates approved by the State Board for Property and Casualty Rates are being used by insurers and rating organizations.	Amended and Passed House Senate Bus. & Labor
HB 1314 Holden	Creating the Oklahoma Risk Retention Act pursuant to the provisions of the Federal Liability Risk Retention Act of 1986.	Amended and Passed House Senate Bus. & Labor
HB 1365 White Steidley	New law requiring written notification of decision not to provide insurance coverage.	Senate Comm. Bus. & Labor
HB 1480 Bastin	Requiring insurance policies to include coverage for certain transplantation operations.	House Comm. Insurance <i>Dormant</i>

Legislation regarding Workers' Compensation is listed below:

SB 23 Taylor	Expanding the purpose of the State Insurance Fund to provide reinsurance and insurance for certain lines other than workers' compensation.	Senate Comm. Judiciary <i>Dormant</i>
SB 25 Stipe	Designating the State Insurance Fund as the exclusive carrier of workers' compensation insurance in Oklahoma.	Senate Comm. Judiciary <i>Dormant</i>
SB 194 Taylor	Requiring workers' compensation insurers to notify policyholders of rate increase requests and the time and place of any hearings to be held to consider such requests.	Senate Comm. Bus. & Labor <i>Dormant</i>
HB 1105 Lewis	Appropriating \$2,475,469 to the Workers' Compensation Administration Fund.	House Comm. Appropriations
HB 1457 Benson	Requiring employee to accept medical rehabilitation after accidental injury in order to retain workers' compensation benefits.	Senate Comm. Judiciary
HB 1459 Hunter	Creating the Workers' Compensation Agency to administer the Workers' Compensation Act.	Senate Comm. Judiciary

Legislation regarding Board of Medical Examiners is listed below:

SB 110 Taylor	Delaying the effective date of the cabinet system of government until July 1, 1989, or until no school district is subject to a reduction in state assistance from the previous fiscal year.	Senate Comm. Appropriations <i>Dormant</i>
SB 161 Cain	Including in the definition of "unprofessional conduct" of medical practitioners the engagement in sexual conduct with a patient.	Senate Comm. Bus. & Labor <i>Dormant</i>
SB 162 Cain	Modifying the composition of the State Board of Medical Examiners to include five licensed physicians and three lay members. OSMA Position: <i>Oppose</i>	House Comm. Rules
SB 211 Smith	Providing that the Board of Medical Examiners shall have the authority to adopt certain rules and regulations and set fees.	Senate Comm. Hum. Resources <i>Dormant</i>
HB 1478 Mentzer	Providing for application qualification of candidates to medical school. OSMA Position: <i>Support</i>	Senate Comm. Bus. & Labor

Legislation regarding expanding the scope of medical practice is listed below:

SB 39 Hooper	Permitting physicians to dispense dangerous drugs to his patients under certain conditions; allowing physicians to furnish drug samples under certain conditions. OSMA Position: <i>Support</i>	Signed by the Governor
SB 144 Green	Requiring that contact lenses be prescribed only by a licensed practitioner.	Senate Comm. Rules <i>Dormant</i>
SB 165 Cullison	"Physical Therapy Practice Act" OSMA Position: <i>Support</i>	Senate on General Order
SB 177 Haney	Removing the requirement that nurse anesthetists must administer anesthesia under the supervision of and in the immediate presence of a licensed physician, osteopath, or dentist.	Senate Comm. Bus. & Labor <i>Dormant</i>
HB 1154 Vaughn	Defining the term "adequately trained" for purposes of performing spinal manipulations. OSMA Position: <i>Support</i>	Senate Comm. Hum. Resources



M. Joe Crosthwait, MD, poses a question during a reference committee meeting.

HB 1401 Hobson	Defining terms and authorities of the Physical Therapy Committee pursuant to the Physical Therapy Practice Act. OSMA Position: <i>Support</i>	Signed by the Governor
HB 1425 Stacy	Deleting a provision which requires certain people to administer anesthesia in the immediate presence of a physician, osteopath, or dentist.	House Comm. Rules <i>Dormant</i>
HB 1487 Hobson	Creating the Oklahoma Board of Nurse Licensure and Nursing Education.	House Comm. Public Health <i>Dormant</i>

Legislation regarding Mental Health is listed below:

SB 75 Cullison	Appropriating \$89,327,905 to the Dept. of Mental Health.	Senate Comm. Appropriations
SB 323 Lamb	Relating to mental health; requiring verification of probable cause to detain certain persons.	House Comm. Mental Health
HB 1157 Duckett	Providing that one person on the Board of Mental Health shall be a lay person.	Senate General Order
HB 1204 Duckett	Providing that certain charges for mental health care be placed on a sliding scale.	Senate Comm. Hum. Resources
HB 1219 Duckett	"Equitable Mental Health Insurance Act"	House Comm. Mental Health <i>Dormant</i>
HB 1283 Duckett	Authorizing the board of county commissioners of each county to hire counselors for the purpose of providing counseling to victims of crime.	Senate Comm. Gen. Govt.
HB 1348 Larason	Providing for the termination of parental rights if the parent has an emotional or mental illness under certain conditions.	Senate Comm. Judiciary

Legislation regarding Indigent Care is listed below:

SB 106 Cullison	Creating the "Oklahoma Indigent Health Care Access Act" prohibiting hospitals from denying emergency services to a person because of inability to pay or by reason of race, religion, or national ancestry. OSMA Position: <i>Monitor</i>	House Comm. Appropriations
SB 160 McCune	Expanding the Oklahoma Indigent Health Care Act to include provisions for primary health care services.	Senate Comm. Hum. Resources <i>Dormant</i>
HB 1307 Anderson	New law providing authority for the Human Services Commission to include in its Medicaid program certain needy infants and children, pregnant and post-partum women.	Senate Comm. Hum. Resources
HB 1451 Williams, P.	Providing a fund to reimburse hospitals participating in the Oklahoma Indigent Health Care Act.	House Comm. Hum. Services
HB 1483 Hill	Transferring Oklahoma Teaching Hospitals from Dept. of Human Services to Oklahoma Medical Center Authority.	House Comm. Hum. Services <i>Dormant</i>

Legislation regarding Tort Reform is listed below:

SB 134 Hooper	Providing that the payment of exemplary damages in tort actions shall be paid equally to the plaintiff and county and state general revenue funds creating the "Damages Limitation Act" removing joint liability in personal injury, wrongful death or property damage actions; setting a 2-year statute of limitations on products liability actions. OSMA Position: <i>Actively Support</i>	Senate Comm. Rules <i>Dormant</i>
SB 183 Leonard	Providing that the liability of each defendant for damage in personal injury, property damage, or wrongful death cases shall be several only, except when the plaintiff is found to be without fault. OSMA Position: <i>Support</i>	House Comm. Judiciary
SB 266 Taylor	Renumbering subsections contained in 12 O.S. 1981, Sections 109 and 110, which place limitations on when and under what circumstances tort actions may be brought.	Senate Comm. Judiciary <i>Dormant</i>
SB 295 Taylor	Removing the requirement that actions for damages for death against any health care provider shall be brought within two years of the date the plaintiff knew of the existence of the death.	House Comm. Judiciary

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SB 350 Hendrick	Creating the "Health Care Provider Malpractice Liability Act"	Senate Comm. Judiciary <i>Dormant</i>
SJR 9 Hooper	Proposed constitutional amendment repealing Section 15, Article VII, which states that all juries shall return general verdicts.	Senate Comm. Judiciary <i>Dormant</i>
SJR 10 Hooper	Proposed constitutional amendment repealing Section 7, Article XXIII, which states that damages for wrongful death may not be taken away or limited and provides exceptions.	Senate Comm. Judiciary <i>Dormant</i>
HB 1038 McCorkell	Providing that provisions for eliminating or limiting the liability of corporate directors or stockholders shall not extend to certain actions. OSMA Position: <i>Support</i>	Senate Comm. Judiciary
SB 1063 Smith	Providing that punitive or exemplary damages shall be payable to the state.	House Comm. Insurance <i>Dormant</i>
HB 1147 Benson	Deleting a provision stating that for purposes of the Governmental Tort Claims Act, a public trust shall not include any hospital operating under a trust authority.	Senate Comm. Judiciary
HB 1174 Holden	Providing that no action for medical malpractice may be commenced before the claimant's complaint has been submitted for mediation and an opinion rendered by the mediator, with exception for an agreement between both parties that an action may be commenced without mediation.	Senate Comm. Judiciary
HB 1175 Holden	Providing that no member of a peer review committee constituted by a hospital related institution, certain societies, or associations shall be deemed liable in damages for any action taken within the scope of the function of such committee.	Senate Comm. Judiciary
HB 1227 Henshaw	"Product Liability Act," outlining types of claims and actions to be deemed product liability actions.	Senate Judiciary Comm.

Legislation regarding Drug/Alcohol Abuse is listed below:

SB 155 Stipe	Creating the "Drug-Free School Act."	Senate Comm. Education <i>Dormant</i>
SB 169 Branstetter	Creating the "Trafficking in Illegal Drugs Act."	House Comm. Crim. Justice
SB 232 Brown	Removing Butorphanol from the list of certain controlled dangerous substances. OSMA Position: <i>Oppose</i>	Senate Comm. Hum. Resources <i>Dormant</i>
SB 268 Dennis	Removing Butorphanol from the list of certain controlled dangerous substances. OSMA Position: <i>Oppose</i>	House Comm. Public Health
SB 301 Miles-LaGrange	Creating the "Adolescent Drug and Alcohol Abuse Education & Prevention Program and Council."	Senate Comm. Education <i>Dormant</i>
SB 306 Hooper	Placing in the Public Health & Safety Laws the "Oklahoma Alcohol and Drug Abuse Services Act."	Amended & Referred to Comm. for Interim Study
HB 1011 Bastin	Requiring triplicate prescription forms for certain types of controlled dangerous substances. OSMA Position: <i>Monitor</i>	House Comm. Public Health <i>Dormant</i>
HB 1013 Bastin	Providing that sentencing for violations relating to certain controlled dangerous substances shall not be subject to suspended sentences. OSMA Position: <i>Monitor</i>	Senate Comm. Crim. Juris.



Table placards like this set the tone for the Presidents' Inaugural Dinner-Dance.

HB 1200 Davis, Frank	Requiring parents of drug or alcohol dependent children to provide for treatment; making failure to provide for treatment a misdemeanor.	Senate Comm. Crim. Juris.
HB 1224 Williams, P.	Authorizing certain persons to petition for the commitment of drug dependent persons to medical or other facilities for treatment.	House Comm. Mental Health <i>Dormant</i>
HB 1274 McMillen	Providing that methadone shall only be used in detoxification programs not to exceed 24 months, without reasons for extension from attending physician. OSMA Position: <i>Support</i>	Senate Comm. Hum. Resources
HB 1305 Anderson	New law providing that health insurance coverage providing benefits for the treatment of alcoholism and drug dependency shall be offered for all health insurance contracts issued or renewed on or after January 1, 1988.	House Comm. Mental Health <i>Dormant</i>
HB 1315 Brewster	Providing for possession of controlled dangerous substances; providing for forfeiture of raw materials in the manufacture of controlled dangerous substances.	Senate Comm. Judiciary
HB 1344 Lewis	Creating the Oklahoma Alcohol and Drug Abuse Prevention and Life Skills Education Act.	Senate Comm. Education
HCR 1005 Bastin-H Brown-S	Expressing legislative support for the prescription abuse data synthesis model	Passed Senate Hum. Resources

Report of the COUNCIL ON MEMBER SERVICES

Subject: **Annual Report**

Presented by: William O. Coleman, MD, Chairman

Referred to: Reference Committee III

Introduction

It is the responsibility of the Council on Member Services to monitor and develop programs that offer direct benefits to physician members of the OSMA. These programs may be developed by the Association or adopted for endorsement when developed by outside organizations. In addition, the Council is also charged with the responsibility of selecting appropriate programs for sponsorship by the Association's new Member Services Corporation that became operational in early 1987.

Services and programs developed or adopted by the Council include a variety of sponsored insurance programs—including the successful professional liability coverage through PLICO and PLICO's health insurance. Additionally, the Council supervises OSMA-sponsored tours and offers numerous other programs each year for members.

The Council is also charged with the responsibility of supervising and maintaining the underwriting program for professional liability insurance through PLICO. This is a contracted function between the OSMA and the PLICO management company, C. L. Frates and Company.

Review of Activities

A. Underwriting Review — The most important function carried out by the Council on Member Services each administrative year has been the continued conduct of the annual underwriting review for the Association-owned Physicians Liability Insurance Company (PLICO).

The Underwriting Plan for PLICO requires that each year the Association's Council review all claims, settlements, or judgments to determine whether or not there is a pattern of losses that could be prevented through the underwriting or loss prevention mechanism.

In addition, the Council conducted individual reviews on problem cases or to resolve underwriting difficulties whenever a physician would apply for coverage and there appeared to be an underwriting problem in the application.

In 1986 and 1987, the Council met approximately four times, primarily for underwriting purposes, but did conduct other Council business in the meantime.

B. Seminars — During the past year the Council has sponsored a number of practice-management, financial planning, and personal planning seminars for physicians and their medical office staffs.

During September and October, six medical office management programs were offered throughout the state and in November and December, seven special evening seminars designed for physicians were offered.

A Financial Planning Program was sponsored during October, a Gearing Up for Retirement Program in February, and two seminars on medical office marketing are scheduled for April.

The Council also sponsored a one-day seminar by the Conomikes Corporation on insurance claim form coding. This program was so successful that two additional programs were sponsored in March on the same subject. In February, two half-day programs were offered back-to-back in Oklahoma City and Tulsa for new medical office employees and collecting medical accounts.

C. Pre-Paid Legal Services — During 1986 the Council decided it wished to sponsor Pre-Paid Legal Services for OSMA members. Pre-Paid Legal Services is a company headquartered in Ada, Oklahoma, offering legal service insurance, similar to health insurance, for a modest premium.

Since the Association's sponsorship began, approximately 60 offices have signed up for the insurance coverage.

D. I.C. Systems — After hearing complaints from a number of physicians in rural areas that they were having difficulty finding collection agencies that would handle their past-due accounts, the Council determined that it wished to endorse the services of I.C. Systems, Inc., a national collection agency. The organization was authorized to send a letter to all Oklahoma physicians notifying them that this was now a sponsored program by the Association and that they were offering their services to OSMA members.

The Council will continuously monitor the service given by the organization.

E. Trans National Financial Services — During the Spring of 1987, the Council endorsed a special gold MasterCard program offered by Trans National Financial Services. In return for the Association's endorsement, the gold MasterCard will be made available to Association members at a very reduced price. However, it was the additional member benefits that convinced the Council to authorize the endorsement. These included a high-limits credit line, no liability for lost or stolen cards, an automatic half million dollars in travel insurance at no additional cost, emergency travel service, an automobile rental deductible insurance policy that's automatic, a special 24-hour message center, lost luggage insurance, other credit card registration service, instant cash advances, and no finance charges if the current purchases are paid in full by the regular due date each month.

F. Specialty Society Services — The Council determined that one of the possible services to be offered by the Association's new Member Services Corporation would be administrative services to medical specialty societies. A plan is under preparation at this time to offer administrative services to all of the specialty societies in the state. This would include such things as membership list maintenance, collection of dues, publication of special newsletters, other communications, and annual meeting or educational meeting planning.

G. Tours — For many years the Association has sponsored tours through INTRAV Corporation, but it has also sponsored its own tours periodically. This past year a special tour to London was sponsored by the Association with side tours into Europe. Although only about 10



Farris W. Coggins, MD, and William O. Coleman, MD, of Oklahoma City, coordinated the reunion of the University of Oklahoma Class of '47.

Oklahoma physicians took the London tour, it was considered a financial success.

The OSMA's sponsored tours through INTRAV continue to be successful. INTRAV is one of the most respected tour operators in the world. The Association has utilized INTRAV for sponsored tours for many years and is extremely well satisfied with the company's professionalism. It works primarily with professional associations representing medical doctors, bankers, lawyers, CPAs, etc.

The OSMA recovers all of its expenses for promoting tours from INTRAV Corporation and is therefore able to make them available to Oklahoma physician-members at no cost to the Association. One of the interesting things about the INTRAV tours is that they are made up from several different states and usually contain an excellent cross-section of other professionals.

In 1986-87, the Association sponsored or is sponsoring the following tours:

1986

Alps to the North Sea (June 30-July 13)
Alaska/Canada Air Sea Cruise (June 25-July 4)
Spain Discovery (April 30-May 13)
Swiss Tyrolean Alps (June 18-July 1)
Scandinavian Capitals Air Sea Cruise
(July 27-Aug. 10)
Canada/New England Air Sea Cruise (Sept. 6-Sept. 20)

1987

South Pacific Air Sea Cruise (Dec. 31-Jan. 17)
(two departure dates) (Jan. 15-Jan. 31)
Grenadines/Orinoco River Air Sea Cruise
(Feb. 1-Feb. 8)
Bali Far East (Feb. 16)
The Danube River (May 21-June 4)

H. OSMA-Sponsored Insurance Plans — Please refer to Attachment I.

I. Fiscal Note — It is the Council's policy to attempt to make each of its programs self-sustaining. However, there are some Council activities that do require expenditures. This past year the Council actually showed a profit of several thousand dollars after expenditures. It is therefore estimated that the Council will not need a budget for 1987-88.

Respectfully submitted,
William O. Coleman, MD, Chairman
Joe S. Hester, MD, Vice-Chairman
William G. Bernhardt, MD
Tim S. Caldwell, MD
Jack T. Dancer, MD
E. Edwin Fair, MD
Michael W. Flaherty, MD
Wilfred S. Gauthier, MD
Joe Ray Hamill, MD
George H. Jennings, MD
John F. Josephson, MD
Herbert M. Kravitz, MD
Thomas A. Marberry, MD
Richard A. McKinne, MD
Francis D. Oakes, MD
Paul O. Shackelford, MD
S. Fulton Tompkins, MD

ATTACHMENT I Group Term Life

The OSMA Group Term Life program offers coverage from \$25,000 to \$300,000 for the physician and his spouse, and from \$10,000 to \$100,000 for the employee of a physician. The Accidental Death benefit is available up to \$100,000 under the Group Term Life program. The combination of these gives a maximum of \$200,000 Accidental Death benefit available under the Oklahoma State Medical Association's program.

Dependent coverage is available at \$12.00 per year for coverage up to \$5,000 for children at home. This \$12.00 per year covers all children regardless of how many children are in the family.

After a physician has been in the program for one year, he or she is eligible to convert to an Ordinary Life policy through Loyalty Life Insurance Company. We have received a manual and conversion applications from Loyalty Life and find their rates very competitive for these older ages.

There are 329 lives on the program.

	1983-84	1984-85	1985-86
Written Premiums	\$63,460	\$90,097	\$93,740
Losses Incurred	-0-	-0-	-0-

GXM-X Disability Income

At this time we have 360 lives on this program. Each six months we drop those physicians who have turned 70 years of age.

Experience is as follows:

	1983-84	1984-85	1985-86
Written Premiums	\$166,262	\$178,495	\$216,245
Incurred Losses	* -0-	83,072	96,469
Ratio	* -0-	46.5%	44.6%

* due to release of claim reserves

There are three benefit levels within the program; all begin the benefit period with the first day of an accident and eighth day of sickness.

Plan L-65 — Accident benefits payable for lifetime. Sickness benefits payable to age 65 or for a two-year maximum period if the disability begins between the 63rd and 70th birthdays. Benefits are payable based on being unable to perform the substantial and material duties of your regular occupation.

Plan L-7 — Accident benefits payable for lifetime. Sickness benefits payable for a 7-year maximum period, but not beyond age 65; for a two-year maximum period if disability begins between the 63rd and 70th birthdays. Benefits are payable based on being unable to perform the substantial and material duties of your regular occupation.

Plan 5-2 — Accident benefits payable for a 5-year maximum period. Sickness benefits payable for a 2-year maximum period. Benefits payable based on being unable to perform the substantial and material duties of your occupation.

The waiting period may be extended, which in turn reduces the premiums.

Included as additional features are:

1. \$1,000 Accidental Death and Dismemberment Benefit
2. Covers physicians fees for treatment for non-disabling injuries, to a maximum of the amount of one week's indemnity provided no other indemnity is payable for such injury under the policy.
3. Premium payments will be suspended, while the policy is in force and prior to age 60, after you receive total disability benefits for six continuous months. Waiver of Premiums continues as long as you continue to receive benefits.
4. Minimum benefit payment periods for specific fractures and dislocations.
5. Benefits are payable regardless of other insurance.

Options under this program are:

1. **Cost of Living Increase** — This feature is automatically added to all newly issued policies for applicants under age 45 who have fully satisfied the Company's underwriting requirements. It can add approximately 10% to your monthly benefits each year until your monthly benefits reach the option maximum of \$4,000.00. You may exercise such option without further underwriting at any of the anniversary dates prior to age 50. You will be notified of its availability on each of the anniversary dates and also of the premium charge for the increase available. You may accept or reject the offer as you see fit.
2. **Residual Disability Benefit** — Residual Disability is a condition whereby: (1) You are unable to perform one or more of the substantial and material duties of your occupation; or (2) are unable to perform all of the substantial and material duties of your occupation for as much time as is normally required. (3) You are not totally disabled. (4) You are under the care of a duly licensed physician, other than yourself, and (5) you suffer a continuous loss of at least 20% of your prior monthly income.

The qualifying period is the period of total and/or residual disability which must precede payment of residual disability benefits. The qualifying period must include 30 days of continuous total disability. If your policy waiting period is 30 days or less, you must select the 30-day qualification period. If your policy waiting period is 90 days, you must select the 90-day qualification period. If your policy waiting period is 180 days, you must select the 180-day qualification period.

The combined period for which either total or residual disability benefits are payable is equal to your maximum benefit period for total disability, subject only to the following conditions: (1) In no event will residual disability benefits be payable beyond age 65. (2) The first six monthly residual disability payments will never be less than 50% of the monthly benefit for total disability.

The following formula is used to determine the residual disability benefit:

$$\frac{\text{Loss of Monthly Income}}{\text{Prior Monthly Income}} \times \frac{\text{Monthly Benefit for Total Disability}}{\text{Total Disability}} = \text{Residual Disability Benefit}$$

Maximum limits under this policy are \$5,000 a month.

Accidental Death and Dismemberment is available up to \$100,000 under this policy.

Hospital Indemnity

Pays a specified amount per day that an insured is a patient in a hospital. This program will pay up to 365 days benefit from \$20.00 to \$200.00 per day. It can include the member, his spouse, and family. The policy does not coordinate with any other health insurance you may have, i.e., the money comes directly to you for each day of hospitalization. You could use it to pay a yardman, a housekeeper, babysitter, or to meet your deductible and co-insurance responsibilities under your group health plan. The policy is not underwritten (no health questions). It, however, provides no benefit for the first 24 months of the policy for any health problems treated in the 12 months before the policy's effective date.

There are 138 lives on this program.

Experience is as follows:

	1983-84	1984-85	1985-86
Written Premiums	\$14,349	\$14,418	\$15,952
Incurred Losses	\$ 3,020	\$ 1,660	\$ 6,540

Accidental Death and Dismemberment

This program provides benefits from \$25,000 to \$200,000 for accidental loss of life and a portion thereof for accidental loss of limb, eyesight, speech, or hearing.

It provides 24 hour protection wherever you go.

There are 189 lives on this program.

	1983-84	1984-85	1985-86
Written Premiums	\$6,392	\$ 6,137	\$ 5,500
Incurred Losses	25,000	25,000	-0-
Loss Ratio	391.1%	407.9%	-0-

Business Overhead Expense

Business Overhead Expense Insurance provides dollars to pay routine office expenses during a disability.

The policy is considered a cost of doing business and its premiums are deductible. The benefits are received on a taxable basis, but are used to pay tax deductible items.

Benefits may be purchased from \$500.00 a month to \$5,000 a month. Benefits are payable for 18 months. Two waiting periods are available: 15 days and 30 days.

There are 219 physicians on the plan.

Experience per calendar year is as follows:

	1984	1985	1986
Written Premiums	\$80,243.28	\$89,986.95	\$93,758.30
Paid Claims	10,500.00	3,483.33	31,506.48
Loss Ratio	11.5%	11.1%	47.05%

OSMA Experience Continental Insurance Company

	Premiums Earned	Losses Incurred	Ratio
Disability Income			
1986	\$216,245	\$ 96,469	44.6
1985	205,779	119,540	58.
1984	178,495	83,072	46
1983	166,262	0*	0*
1982	161,612	67,017	41
1981	135,017	191,251	142

*due to release of reserve

Hospital Indemnity

1986	\$15,592	\$ 6,540	42
1985	17,455	11,620	67
1984	14,418	1,660	11
1983	14,349	3,020	21
1982	15,185	4,903	32
1981	12,922	9,940	77

AD&D

1986	\$ 4,212	0	
1985	5,862	0	0
1984	6,137	25,000	408
1983	6,392	25,000	391
1982	6,944	0	0
1981	6,414	0	0

OSMA Experience Combined Insurance Company

	Written Premiums	Paid Claims	Ratio
Business Overhead			
1986	93,758.30	31,506.48	47.05
1985	89,986.25	3,483.33	11.1
1984	80,243.28	10,500.00	11.5
1983	62,235.48	2,350.00	14.5
1982	51,540.31	4,446.66	17.4
1981	42,219.45	1,500.00	

Report of the OKLAHOMA MEDICAL POLITICAL ACTION COMMITTEE

Subject: Annual Report

Presented by: Larry L. Long, MD, Chairman

Referred to: Reference Committee III

Introduction

The Oklahoma Medical Political Action Committee is a voluntary, unincorporated entity made up of individual physicians, spouses, residents, and students interested in

helping political candidates become elected to office. OMPAC is an independent and autonomous organization managed by a Board of Directors. The Board of Directors has control over the policies and activities of the Committee and serves without compensation. The OMPAC Board conducts the business of the Committee and otherwise meets several times during an election year to distribute OMPAC funds to candidates.

Review of Activities

OMPAC's report to the 1986 House of Delegates stated that its goals for 1986 were to:

- (1) Increase membership above the 1,000 member mark
- (2) Urge physicians' spouses to join OMPAC
- (3) Raise \$100,000 for PAC contributions
- (4) Explore the possibility of establishing a resident/student membership program

I am happy to report that each of the above mentioned goals was attained and exceeded. The final membership count for 1986 was 1,367 members. This record membership level was greatly enhanced by the OSMAA and the resident and student members of the OSMA. OMPAC's 1985/1986 financial report showed contributions in excess of \$120,000.

During the 1986 election cycle, your political action committee was instrumental in the election of many new members of the Oklahoma State Legislature. Similarly, OMPAC was a major entity helping to deny the re-election bid of six trial attorney legislators; six votes against tort reform. Overall, OMPAC had a winning percentage of 90% in the 1986 General Election.

Additional activities included the production of the "first ever" OMPAC brochure, as well as taking an active role in an AMPAC videotape featuring OSMA President Norman L. Dunitz, MD. OMPAC support for both parties in all elections is best demonstrated in the October, 1986 OSMA newsletter. (Attachment)

Financial/Membership Report as of April 30, 1987:

OMPAC Contribution Account:	\$37,122.46
OMPAC Contribution to AMPAC to date:	\$24,510.00
Auxiliary Membership:	84
Resident/Student Membership:	21
Regular Member (\$50.00)	714
Sustaining Member (\$100.00)	143
"200 Club" Member (\$200.00)	39
Total Membership 1987 to date	1,001

Auxiliary Membership Report:

Auxiliary Membership (\$30.00)	66
Auxiliary Membership (\$50.00)	12
Auxiliary Membership (\$100.00)	2
Auxiliary Membership (\$200.00)	4
Total Auxiliary Members to date	84*

*(These totals are included in the overall OMPAC membership figures listed above)

Conclusion

The Oklahoma Medical Political Action Committee will continue to strive for bipartisan excellence in every aspect of political action. The support of each member of the OSMA and OSMAA is very much appreciated.

Respectfully submitted,
Larry L. Long, MD, Chairman

OSMA NEWS Edition Special Edition

October, 1986

GENERAL ELECTION — 1986

The Oklahoma Medical Political Action Committee, through your support, is now completing one of the most successful years in OMPAC's history!! Your involvement has enabled OMPAC's membership to increase over 70%, thereby giving organized medicine a strong financial base to support our friends and defeat our enemies in this year's elections.

This Special Edition of the OSMA News is designed to inform the OSMA membership of OMPAC's support. The individuals listed and UNDERLINED are supported by OMPAC and a brief explanation for this support follows each UNDERLINED candidate. OMPAC's support for the candidates listed is derived by physician and spouse input, statistical analysis of the race and the candidates' willingness to work with the OSMA in its various legislative efforts during the previous session.

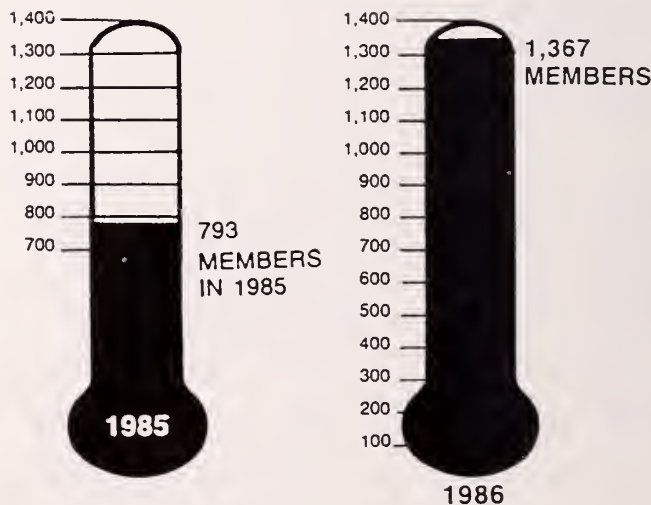
The OMPAC Board of Directors has been involved in over 70 races this election year. In the Primary Election on August 26, 1986, OMPAC was involved in 50 races and won 43 of those races for an 86% winning percentage. Similarly, the Run-Off Election on September 16, 1986, involved OMPAC in 14 races winning 10 of the races for a 71% winning percentage.

Through OMPAC's support, the Primary and Run-Off Elections ousted 4 attorneys in the Oklahoma State Senate. Senators Melvin Porter, Al Terrill, Jim Howell and John Young, all votes against our tort reform efforts, will not return in 1987.

Thanks to you, members of the OSMA and the OSMAA, OMPAC has become a force with which legislators must reckon. For your past and future support of OMPAC, I thank you.

To quote the great performer Al Jolson, "You ain't seen nothing yet."

Larry L. Long, MD, Chairman, OMPAC



OKLAHOMA STATE SENATE

DISTRICT #4

LARRY DICKERSON (D) Poteau, OK - Strong Democratic district. Local physician support.
Richard Strong (R) Spiro, OK

DISTRICT #6

SENATOR ROY BOATNER (D) Calera, OK — Supportive of health issues/tort reform. Member of Human Resources Committee.
James Braly (R) Durant, OK

DISTRICT #11

MAXINE HORNER (D) Tulsa, OK — Favorable recommendation from Congressman Jones. Has expressed willingness to work with OSMA.
Carlos J. Chappelle (R) Tulsa, OK

DISTRICT #16

Sen. Lee Cate (D) Norman, OK
GARY GARDENHIRE (R) Norman, OK — OMPAC is supporting this campaign on recommendation from local physicians. Strongly supported by physician community.

DISTRICT #20

Dennis A. Coates (D) Tonkawa, OK
OLIN BRANSTETTER (R) Ponca City, OK — Favorable recommendation from community

DISTRICT #22

Robert L. Crout (D) Mustang, OK
SENATOR RALPH "BUTCH" CHOATE (R) Hennessey, OK — Supportive of tort reform/health issues.

DISTRICT #36

SENATOR FRANK RHODES (R) Catoosa, OK — Sympathetic to medical issues/tort reform. Member of Human Resources Committee.
James Hogue (D) Tulsa, OK

DISTRICT #38

ROBERT M. KERR (D) Altus, OK — Strong physician support.
Kenneth Schimmer (R) Custer, OK

DISTRICT #40

Sen. Mike Combs (D) Bethany, OK
LEO KINGSTON (R) Oklahoma City, OK — Has contacted OMPAC personally — Conservative candidate willing to work with OSMA.

DISTRICT #42

Carolyn F. Burkes (R) Midwest City, OK
DAVE HERBERT (D) Midwest City, OK — Strong physician support.

DISTRICT #46

Sen. Bernest Cain (D) Oklahoma City, OK
TOM HILL (R) Oklahoma City, OK — Physician support. Opponent is pro mandatory assignment.

DISTRICT #52

J. Mike Lawter (D) Oklahoma City, OK
HOWARD H. HENDRICK (R) Bethany, OK — Physician support/pro tort reform. Opponent voted against tort reform. VERY KEY RACE!!

OKLAHOMA HOUSE OF REPRESENTATIVES

DISTRICT #3

REP JAMES HAMILTON (D) Poteau, OK — Author of tort reform. Member of Select Committee on Insurance Rates and Tort Claims.
Regna Lee Wood (R) Spiro, OK

DISTRICT #4

ROBERT P. MEDEARIS (D) Tahlequah, OK — Ex-legislator with strong community support. Well respected.
Rick D. Farmer (R) Park Hill, OK

DISTRICT #8

Larry Rice (D) Pryor, OK
REP J. D. WHORTON (R) Pryor, OK — Supportive of tort reform/health issues. Member of Human Resources Committee.

DISTRICT #9

DEWAYNE STEIDLEY (D) Claremore, OK — District should go Democrat. Candidate may be cultivated.
Don Wasson (R) Claremore, OK

DISTRICT #19

REP GARY SHERRE (D) Snow, OK — Supportive of health issues/tort reform. member of Professions & Occupations Committee.
Clint Davis (R), Hugo, OK



OSMA Executive Director David Bickham and Legal Counsel Ed Kelsay continue their work behind the scenes.

DISTRICT #23

REP KEVIN EASLEY (D) Tulsa, OK — Candidate for the future. Supportive of tort reform/good relationship with OSMA.
Sue Tibbs, (R) Tulsa, OK

DISTRICT #25

REP LONNIE ABBOTT (D) Ada, OK — Member of leadership team. Supportive of tort reform/health issues.
Roger Thorpe (R) Ada, OK

DISTRICT #27

REP STEVE LEWIS (D) Shawnee, OK — Chairman of Appropriations Committee. Supportive of health issues/tort reform. Member of Human Resources Committee.
Carl Franklin (I) Shawnee, OK

OMPAC

DISTRICT #32

REP. CHARLIE O. MORGAN (D) Prague, OK — Supportive of tort reform/health issues. Member of Insurance Committee.
Patsy Alsbrook (R) Wellston, OK

DISTRICT #33

REP. MIKE MORRIS (R) Cushing, OK — Very supportive of tort reform. Easy to work with.
Calvin McEntire (D) Cushing, OK

DISTRICT #35

REP. LARRY FERGUSON (R) Cleveland, OK — Very supportive of tort reform.
Cam Favaro (D) Terlton, OK

DISTRICT #36

REP. DON ANDERSON (D) Tulsa, OK — Supportive of health issues. Easy to work with. Vice Chairman of Human Services Committee.
John Handshy (R) Skiatook, OK

DISTRICT #39

LENARD BRISCOE (D) Kingfisher, OK — Physician support.
REP. STEVEN BOECKMAN (R) Dover, OK — Physician support.

DISTRICT #41

Dean B. Brown (D) Kremlin, OK
REP. JOHN McMILLEN (R) Enid, OK
Supportive of tort reform/former hospital administrator. Member of Human Services Committee and Professions and Occupations Committee.

DISTRICT #43

REP. HAROLD HALE (D) El Reno, OK — Supportive of health issues.
Bill Jeffrey (R) El Reno, OK

DISTRICT #44

REP. CAROLYN THOMPSON (D) Norman, OK — Supportive of health issues. Member of Mental Health Committee.
Michael E. Moore (R) Norman, OK

DISTRICT #45

REP. CAL HOBSON (D) Lexington, OK — Generally supportive of health issues/open door to OSMA.
Richard Gallant (R) Norman, OK

DISTRICT #46

Vickie White (D) Norman, OK
REP. JOE CUNNINGHAM (R) Norman, OK — Supportive of health issues/tort reform. Member of Human Services Committee and Mental Health Committee.

DISTRICT #50

P. O. Kidd (D) Duncan, OK
ED APPLE (R) Duncan, OK — Strong physician support.

DISTRICT #53

JOHN D. LASSITER (D) Norman, OK — Pharmacist
Evelyn Orth (R) Norman, OK

DISTRICT #54

Keith R. Treadway (D) Oklahoma City, OK
REP. KEN McKENNA (R) Oklahoma City, OK — Appreciative of medicine's views.

DISTRICT #58

Roscoe Hill (D) Woodward, OK
REP. LEWIS M. KAMAS (R) Freedom, OK — Strong physician support.

DISTRICT #66

REP. M. DAVID RIGGS (D) Sand Springs, OK — Strong leadership abilities. Supportive of most medical issues. Member of Judiciary Committee. Likely Senate candidate should Senator Hopkins win Corporation Commission race.
Lee Everett (R) Tulsa, OK

DISTRICT #68

REP. JAY LOGAN (D) Tulsa, OK — Supportive of health issues/tort reform. Member of Human Services Committee.
E. J. Jerry Strout (R) Sand Springs, OK

DISTRICT #70

REP. PENNY WILLIAMS (D) Tulsa, OK — Strong physician support. Very supportive of health issues.
Larry W. Self (R), Tulsa, OK

DISTRICT #78

Larry Cowan (D) Tulsa, OK
REP. FRANK PITEZEL (R) Tulsa, OK — Physician support/pro health issues.

DISTRICT #80

Fred Dorrell (D) Broken Arrow, OK
REP. JOE GORDON (R) Broken Arrow, OK — Easy to work with/supportive of health issues.



At the first meeting of the OSMA's Young Physician Section is Philip Mosca, MD, Oklahoma City. Behind him is OSMA Associate Director Robert W. Baker III.

DISTRICT #81

Joe Park (D) Edmond, OK
REP. GAYLON STACY (R) Edmond, OK — Always supportive of medicine/knowledgeable of health issues. Member of Human Services Committee and Insurance Committee.

DISTRICT #83

John Williams (D) Oklahoma City, OK
REP. JOE HEATON (R) Oklahoma City, OK — Attorney on OSMA's side. Targeted for defeat by trial attorneys. Member of Judiciary Committee.

DISTRICT #84

Vernon Askew (D) Oklahoma City, OK
JOHN BUMPUS (R) Bethany, OK — Medical doctor. Need we say more!

DISTRICT #85

Michael J. Harkey (D) Oklahoma City, OK
REP. MIKE HUNTER (R) Oklahoma City, OK — Attorney on OSMA's side. Targeted for defeat by trial attorneys. Member of Judiciary Committee.

DISTRICT #90

Bruce Thompson (D) Oklahoma City, OK
CHARLES KEY (R) Oklahoma City, OK — Insurance business. Known personally. Will be supportive of tort reform.

DISTRICT #91

KEITH LEFTWICH (D) Oklahoma City, OK — Open communication has been achieved with this candidate.
Charles Stinson (R) Oklahoma City, OK

DISTRICT #95

REP. DAVID CRAIGHEAD (D) Midwest City, OK — Supportive of health issues/tort reform.
J. Robert Blakeburn (R) Midwest City, OK

DISTRICT #96

CARL THOMPSON (R) Choctaw, OK — Should be supportive of OSMA efforts.
Jim Zimmerman (D) Harrah, OK

DISTRICT #97

REP. KEVIN COX (D) Oklahoma City, OK — Supportive of tort reform. Targeted for defeat by trial attorneys. Chairman of Insurance Committee. Member of Human Services Committee and Public Health Committee.
Corlandus Lang, Jr. (R) Oklahoma City, OK

DISTRICT #99

REP. FRED DYER WILLIAMS (D) Oklahoma City, OK — Supportive of tort reform/health issues. Member of Human Services Committee and Public Health Committee.
Dortha Belser (R) Oklahoma City, OK

DISTRICT #101

SUE MILTON (R) Midwest City, OK — Supportive of most health issues.
Jeff Hamilton (D) Midwest City, OK

GOVERNOR

DAVID WALTERS (D) Oklahoma City, OK — Strong physician support.

HENRY BELLMON (R) Red Rock, OK — Strong physician support.

LIEUTENANT GOVERNOR

TIM LEONARD (R) Beaver, OK — Has shown concern for OSMA issues. OSMA maintains an "open door" with this candidate.

Robert S. Kerr III (D) Oklahoma City, OK

ATTORNEY GENERAL

ROBERT HENRY (D) Shawnee, OK — Ex-legislator. Has been helpful on medical issues. Physician support is visible.

BRIAN GRIFFIN (R) Oklahoma City, OK — Has given "open door" to OSMA. Physician support is visible.

U.S. SENATE

SENATOR DON NICKLES (R) Ponca City, OK — Physician support/coauthor of Federal Tort Reform.

CONGRESSMAN JAMES JONES (D) Tulsa, OK — Fought Mandatory Assignment and Physician Fee Freeze/physician support.

U.S. CONGRESS

CONGRESSIONAL DISTRICT #1

JAMES INHOFE (R) Tulsa, OK — Physician support/opponent is attorney.

Gary Allison, (D) Tulsa, OK

CONGRESSIONAL DISTRICT #2

CONGRESSMAN MIKE SYNAR (D) Muskogee, OK — Author of ban on tobacco advertising/physician support is bringing greater access

Gary K. Rice (R) Catoosa, OK

CONGRESSIONAL DISTRICT #3

CONGRESSMAN WES WATKINS (D) Ada, OK — Strong physician support. Always willing to work with OSMA.

Patrick K. Miller (R) Snow, OK

CONGRESSIONAL DISTRICT #4

CONGRESSMAN DAVE MCCURDY (D) Norman, OK — Strong physician support. Always willing to work with OSMA.

Larry Humphreys (R) Velma, OK

CONGRESSIONAL DISTRICT #5

CONGRESSMAN MICKEY EDWARDS (R) OKC, OK — Strong physician support.

Always willing to work with OSMA

Donna Compton (D) Oklahoma City, OK

part of the state. It soon became apparent that Medical Director J. Darrel Smith, MD, OKC, would require assistance to meet the new demand for help.

The OSMA Board of Trustees at its February meeting approved appointing a PRC Assistant Medical Director for Eastern Oklahoma. The Committee unanimously recommended Mason Lyons, MD, Tulsa, who accepted the appointment.

In addition to its direct work with physicians, PRC Committee members, on request, have assisted other professionals, e.g., DOs, dentists, and veterinarians.

The Committee also participates in a national AMA project to gather statistics on disease of addiction in physicians.

The Committee would like to improve in one area — the number of presentations before hospital medical staffs, county medical societies, and auxiliary groups.

Finally, the Committee wishes to report that its relationship with the Board of Medical Examiners remains excellent.

Respectfully submitted,
Ted Clemens, Jr., MD, Chairman

Homer V. Archer, MD

Macaran A. Baird, MD

Luis A. Barrios, MD

Ted J. Brickner, Jr., MD

John C. Chelf, MD

Donald L. Cooper, MD

Raymond L. Cornelison, MD

Marcus L. Cox, MD

Carl F. Critchfield, MD

Frank Crowe, MD

David V. Eakin, MD

Robert G. Ellis, MD

Donald C. Karns, MD

Thomas S. Llewellyn, MD

George C. Moore, MD

William T. Morris, MD

Donald A. Reid, MD

James R. Rhymer, MD

Clarence R. Roberts II, MD

Michael E. Sandlin, MD

Charles J. Shaw, MD

J. Darrel Smith, MD

Joseph W. Stafford, MD

Rhonald A. Whiteneck, MD

V. William Wood, MD

M. Michael Sulzycki, OSMA

Report of the PHYSICIAN RECOVERY COMMITTEE

Subject: Annual Report

Presented by: Ted Clemens, Jr., MD, Chairman

Referred to: Reference Committee III

Once again the OSMA Physician Recovery Committee is able to report significant progress.

The Committee reported last year some 100 physicians were being followed in treatment or recovery.

This year the Committee assists and acts as an advocate for over 150 physicians.

The Physician Recovery Telephone Number is published monthly in the OSMA JOURNAL and OSMA News. The Committee also published an informational brochure this year.

Favorable articles on the Committee have appeared in Oklahoma City and Tulsa newspapers and have been picked up by the wire services. In addition, the CBS affiliate in Oklahoma City produced a four-part news special on the Committee.

The fifty percent increase in the number of physicians requiring the Committee's help created large demands on all Committee members. Always strong in Central Oklahoma, more inquiries were received from the eastern

THE 1987 INAUGURAL

Address of

Norman L. Dunitz, MD

OSMA President, 1986-87

Dear colleagues, friends, ladies, and gentlemen:

Tonight marks the end of my term as president of your medical association. This past year I have tried to fight our battles with varying degrees of success; and as I have reported to you in the House of Delegates, these conflicts have been fraught with pleasures and frustrations. At present, as the year draws to an end, I find myself indulging in reveries, as if a chapter of my life is being completed.

Often at night in the past, when I have been troubled or I am having difficulty sleeping, I have tended to pick up a book of poetry to try to find relaxation. For some reason, as I considered what I would like to say to you tonight, it struck me that my life these past few years and my efforts in the forum of medical affairs have been like a mélange of poems that keep coming back to me over and over. I can see myself reflecting various moods. So, if you don't mind, I would like to take you through some of these situations so that you, too, can see my emotions and my feelings over the recent years.

Some years ago when I first became involved with my community, Tulsa County, medical affairs, I realized that my professional life had paralleled a favorite poem which I frequently quoted by Samuel Foss:

Let me live in my house by the side of the road
Where the race of men go by
They are proud, they are bad, they are weak, they
are strong,
Wise foolish, so am I
And why should I sit in the scorner's seat
Or herald the cynic's band
Let me live in my house by the side of the road
And be a friend to man.

This emotion, ladies and gentlemen, sounds good, but we doctors can no longer afford this luxury. Shakespeare put it extremely well when Hamlet says:

To be or not to be, that is the question
Whether tis nobler in the mind to suffer
The slings and arrows of outrageous fortune
Or to take arms against a sea of troubles
And by opposing, end them.

Yes, if one has no purpose in this life, then life really does become meaningless. As I went further into our medical problems, and especially this past year, the threats and dangers to our profession appeared to have grown more and more massive and to have surrounded us from all sides. I was transported to Tennyson's famous charge:



Cannon to the right of them
 Cannon to the left of them
 Vollyed and thundered
 Stormed at with shot and shell
 Boldly they rode and well
 Into the jaws of death,
 Into the mouth of Hell
 Rode the 600.

And bloodied we were at times! But we were successful enough to see the value of our efforts and to realize that good medicine, quality medicine, and caring care of the ill still had a chance to survive.

Now the entire saga has come full circle. No, I can no longer "sit by the side of the road," but ever better, I feel like:

Abou Ben Adhem, (may his tribe increase)
 Awoke one night from a deep dream of peace
 He saw an angel writing in a book,
 And he asked her what she wrote. She replied,
 "the names of those who love the Lord," "and
 am I in it?" he asked. "No", she said,
 whereupon Abou replied
 "Write me as one who loves his fellow man."
 The next night the angel came again.
 And showed the names whom love of God had
 blessed,
 And lo!, Ben Adhem's name led all the rest.

So as I leave this office, with its emotional peaks and its depths of frustrations, I leave with one strong feeling that Tennyson again reflected so well:

Sunset and evening star
 And one clear call for me
 And may there be no moaning of the bar
 When I put out to sea.

The profession of the Art of medicine is the most honorable of all of God's work. You and I, however, are merely stewards of this, and we must protect it against the ravages of the envious, the criticisms of the ignorant, and the avariciousness of the greedy.

If we do, and if we can successfully pass this heritage on to the future generation of physicians, then and only then:

Can we live in a house by the side of the road
 Where highways never ran
 Just live in that house by the side of the road
 And be a friend of man.

For this past year, you, my peers, have given to me the greatest of all gifts possible. You have allowed me to serve you.

As I leave this office
 My secretary thanks you,
 My partner thanks you,
 My wife thanks you,
 And dear friends and colleagues,
 I thank you.

Remarks of M. Joe Crosthwait, MD OSMA President 1987-88

You know, I have been involved in organized medicine for 30 years. I have sat out there during the dinner and festivities honoring our new presidents and I have always wondered what it would feel like to be honored as the president of the Oklahoma State Medical Association. I can tell you now.

It feels great. It makes me very proud.

Proud to be a member of this state medical association — in my opinion, the most dynamic and progressive medical association in the AMA federation.

It will be with a sense of humility and responsibility that I will accept the presidency of this great organization. It will be with a deep sense of respect for those who have gone on before me and have labored in the cause of organized medicine.

We have many problems, you and I; some we have

A man of many talents, OSMA President Joe Crosthwait picks up a saxophone and joins the band. Dr Crosthwait was once a member of Les Brown's Band of Renown.



brought on ourselves, by not maintaining the vigilance necessary to guarantee the continuing freedom to practice medicine in a way that makes the American medical



system second to none, and has made it the envy of the world.

Other problems have been brought on by the big corporations who would turn the practice of medicine into a heartless contest for the biggest dollar bottom line.

But this great medical care system — the envy of the world — was not developed by HMOs, PPOs, IPAs, cookbook medicine from PSROs, PPOs and other third parties or marketing strategies.

It was developed by hard-working physicians, in the interests of their patients. And this system has extended the lifespan of the American people 15 years during the last 25 years. And let me tell you, these doctors did not need a Music Man to lead them.

If we are to meet the challenges of the next few years, we must have unity, and I believe I see signs of this unity developing. It has been said that if you lock a doctor in the closet by himself, within 20 minutes he will be having a confrontation with himself.

I suppose this individualism is the one thing that we all have in common — the ability to make life and death decisions in the middle of a lonely night.

But if we are going to continue to be our patients' advocates, if we are going to protect this great medical system, if we are going to protect the freedom to practice the art and science of medicine, we must be unified.

Unified in spirit and purpose, setting aside our personal professional agendas, replacing them with agendas that protect this system, our patients, and finally — and very importantly — protect ourselves from further encroachment in the practice of medicine.

I thank you for the honor you have bestowed on me. I thank you for the trust you have placed in me.

I shall do my best in your interests.

*Let us never forget
that we became physicians to heal,
to comfort those who are ill or injured. . . .
Let our offices be sanctuaries
where our patients come for comfort and relief
and we, the physicians, think only of
how best we can minister to the needs of others.*

— M. Joe Crosthwait, MD

Motrin® 800 TABLETS mg ibuprofen



Extra strength
Convenience
Economy

Upjohn



A Century
of Caring
1886-1986

ANNOUNCING NEW

Keflet™ TABLETS cephalexin

All the advantages of cephalixin in a convenient tablet form

- Backed by over 15 years of clinical experience
- Smaller tablet is specially shaped and coated for easier swallowing
- May enhance patient compliance, particularly among the elderly
- Tablet dosage form may be appreciated by patients of all ages

NEW Keflet Tablets are available as:



Keflet is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-sensitive patients.

Brief Summary. Consult the package literature for prescribing information.
Indications and Usage: Keflet™ Tablets (cephalexin, Osta) are indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Respiratory tract infections caused by *Streptococcus pneumoniae* and group A β -hemolytic streptococci (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. Keflet is generally effective in the eradication of streptococci from the nasopharynx, however, substantial data establishing the efficacy of Keflet in the subsequent prevention of rheumatic fever are not available at present.)

Otitis media due to *S. pneumoniae*, *Haemophilus influenzae*, staphylococci, streptococci, and *Nisseria calarrhais*

Skin and skin structure infections caused by staphylococci and/or streptococci

Bone infections caused by staphylococci and/or *Proteus mirabilis*
Genitourinary tract infections, including acute prostatitis, caused by *Escherichia coli*, *P. mirabilis*, and *Klebsiella sp*

Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.
Contraindication: Keflet is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEPHALIXIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to Keflet.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics.

Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Precautions: General—Patients should be followed carefully so that any side effects or unusual manifestations of drug idiosyncrasy may be detected. If an allergic reaction to Keflet occurs, the drug should be discontinued and the patient treated with the usual agents (eg, epinephrine or other pressor amines, antihistamines, or corticosteroids).

Prolonged use of Keflet may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Keflet should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

As a result of administration of Keflet, a false positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—The daily oral administration of cephalixin to rats in doses of 250 or 500 mg/kg prior to and during pregnancy, or to rats and mice during the period of organogenesis only, had no adverse effect on fertility, fetal viability, fetal weight, or litter size. Note that the safety of cephalixin during pregnancy in humans has not been established.

Cephalixin showed no enhanced toxicity in neonatal and newborn rats as compared with adult animals. Nevertheless, because the studies in humans cannot rule out the possibility of harm, Keflet should be used during pregnancy only if clearly needed.

Nursing Mothers—The excretion of cephalixin in the milk increased up to 4 hours after a 500-mg dose, the drug reached a maximum level of 4 µg/mL, then decreased gradually, and had disappeared 8 hours after administration. Caution should be exercised when Keflet is administered to a nursing woman.

Adverse Reactions: *Gastrointestinal*—Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely. The most frequent side effect has been diarrhea. It was very rarely severe enough to warrant cessation of therapy. Dyspepsia and abdominal pain have also occurred. As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.

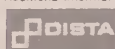
Hypersensitivity—Allergic reactions in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson Syndrome, or toxic epidermal necrolysis have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported.

Other reactions have included genital and anal pruritus, genital moniliasis, vaginitis and vaginal discharge, dizziness, fatigue, and headache. Eosinophilia, neutropenia, thrombocytopenia, and slight elevations in SGOT and SGPT have been reported.

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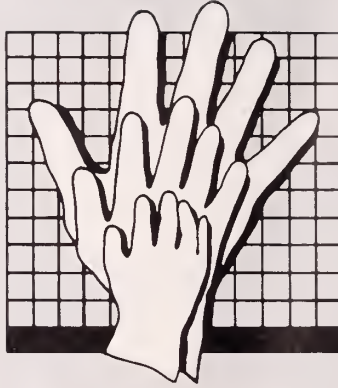
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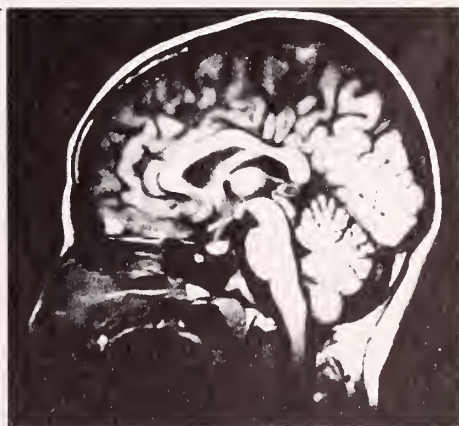
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Illustrations other than the author's will not be accepted for publication unless accompanied by written permission from the original source. Illustrations should be labeled with the author's name and must be numbered in the order in which they are referred to in the article. The quality of all illustrations must be in keeping with the quality of the magazine.

News

Readers are encouraged to submit news items of interest to Oklahoma physicians. Where dates of meetings, etc., are important, please remember that each issue closes on the first day of the *preceding* month and reaches subscribers in the latter half of the month of publication.

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Back Issues

Microfilm copies of back issues of the JOURNAL can be purchased from University Microfilms International, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

LOSS PREVENTION SEMINAR ATTENDANCE MANDATORY

Attendance at an OSMA-PLICO sponsored Loss Prevention Seminar is now mandatory for all PLICO-insured physicians at least once every three years. **If a physician has never attended a seminar, he or she must attend one during 1987.** If a physician has not attended a program since 1984, he or she must attend this year, also.

The change making seminar attendance mandatory was implemented by the PLICO Board of Directors in late 1985, and a special endorsement outlining the requirement was included in all 1986 PLICO professional liability insurance policies. Any physician needing to attend in 1987, and failing to do so, will not be eligible for renewal of his or her PLICO professional liability insurance for calendar year 1988.

A Seminar Registration Form is located at the bottom of this page and a schedule of upcoming seminars is included. The registration form may be used for any seminar, but please **specify the date** you would like to attend. It is advisable to pre-register for the seminar you would like to attend.

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August 8	Sat. 2-5 p.m.	WOODWARD Park Inn
September 19	Sat. 8:30 a.m.-11:30 a.m.	McALESTER Holiday Inn
September 26	Sat. 8:30 a.m.-11:30 a.m.	OKLAHOMA CITY Lincoln Plaza

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THE LAST WORD

■ **Leon Horowitz, MD, and David S. Hurewitz, MD,** Tulsa allergists, presented a seminar entitled "Update in Allergy" on May 12. The meeting, held in conjunction with the Tulsa District of the Oklahoma Pharmaceutical Association, included presentations on pharmacological and nonpharmacological management of allergy, and drug reactions and interactions in allergy. Approximately 85 Tulsa-area pharmacists and pharmaceutical representatives attended the seminar, held in the Tulsa Marriott Hotel.

■ **Modhi Gude, MD, an endocrinologist in** Oklahoma City, is currently sponsoring a series of free seminars for the public. Included are classes on diabetes and its management, cholesterol and fat screening, hypertension, and nutrition and weight control.

■ **Tullos O. Coston, MD, Oklahoma City ophthalmologist,** has been named Phi Beta Kappa of the Year by the Phi Beta Kappa Association of Oklahoma City. The award was presented on May 7 by US District Judge Ralph Thompson, who said, "Dr Coston is being honored for having best exemplified the ideals of scholarship and service to his fellow man."

■ **Tulsa cardiologist James R. Higgins, MD,** is the author of a chapter in *Conn's Current Therapy 1987* entitled "Angina Pectoris."

■ **Wendell R. Sylvester, MD, Oklahoma City,** president of Oklahoma-Mexico Partners of the Americas, and Governor Henry Bellmon, honorary chairman, recently were presented a charter of excellence by the vice chairman of the National Association of Partners of the Americas. "We are a civilian volunteer organization that works on a person-to-person basis with our Mexican neighbors," says Sylvester. "We provide services such as medical assistance, technical instruction, agricultural projects, and anything else they need." **James H.**

Little, MD, Oklahoma City, for example, presented a seminar to 20 ophthalmologists in a Guadalajara hospital; he donated his time and travel expenses to do so.

■ **The National Board of Medical Examiners (NBME)** has presented the NBME Distinguished Service Award to **Gordon H. Deckert, MD,** in recognition of his outstanding service and in gratitude for his many contributions to the board. Dr Deckert is David Ross Boyd professor and chairman, Department of Biochemistry and Behavioral Sciences at the University of Oklahoma College of Medicine. He has served as a member of many NBME committees and currently is serving as chairman of the FLEX Component 1 Committee.

■ **Robert W. Baker III, associate director at the** Oklahoma State Medical Association (OSMA) since August 1984, was recently named assistant to the executive director. He will, in addition to his new duties, continue as director of the Oklahoma Medical Political Action Committee (OMPAC). Prior to joining OSMA, Baker worked as administrative assistant to Senator Rodger A. Randle and as research analyst for the Oklahoma Corporation Commission. A Tulsa native, he is a 1980 graduate of the University of Oklahoma.

■ **The University of Oklahoma School of** Medicine's Class of 1927 held its 60-year reunion in Oklahoma City last month. Of the original class of 42, only 7 are now living, reports **Hervey A. Foerster, MD,** Oklahoma City. In addition to Dr Foerster, they are: **Henry W. Harris, MD,** Oklahoma City; **Clifford W. Moore, MD,** Stillwater; **John B. Miles, MD,** Anadarko; **Frannie Lou Leney Hayward, MD,** Tulsa; **George LeRoy Goodman, MD,** Yukon; and **Juan S. Gonzalez, MD,** Nogales, Ariz. Dr Foerster notes proudly that the Class of '27 produced Oklahoma's first neurosurgeon, Harry Wilkins, MD, and the state's first psychiatrist, Coyne Campbell, MD. □

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- Only 1/3 the dropout rate due to side effects of amitriptyline alone, although the incidence of side effects is similar¹

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.


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References: 1. Feighner JP, et al. *Psychopharmacology* 61:217-225, Mar 22, 1979. 2. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

Limbitrol[®] Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated, sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring

reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, ototoxicity, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: Double strength (DS) Tablets, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and Tablets, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt). Available in bottles of 100 and 500, Tel-E-Dose[®] packages of 100, Prescription Paks of 50.



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to find
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60,073 patients (90%) who started on INDERAL LA stayed on INDERAL LA.^{1*}

Surprising? Not really.

Because most patients on INDERAL LA (propranolol HCl) don't even know it's working.

A recent double-blind, placebo-controlled, crossover study in 138 hypertensive patients² revealed that INDERAL LA has a side effects profile unsurpassed by atenolol or metoprolol — which shows how well-tolerated once-daily INDERAL LA can be.

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The patients in the nationwide compliance trial were no different from yours. Generally when the antihypertensive regimen is complicated, compliance may become a problem. So, the effectiveness of INDERAL LA as once-daily monotherapy is a big plus. Of the remaining hypertensives in the program, 36% were treated merely with the addition of a diuretic to INDERAL LA.

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ONCE-DAILY
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(PROPRANOLOL HCl) **LONG ACTING CAPSULES**

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA.

The one you know best keeps looking better

Please see next page for brief summary of prescribing information



The one you know best keeps looking better

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)

INDERAL® LA brand of propranolol hydrochloride (Long Acting Capsules)

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension. It may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first-degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema) PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3 and decreasing T_3 .

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should

be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncope attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbital, and rifampin accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrene and lidocaine have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS. INDERAL is excreted in human milk. Caution should be exercised when INDERAL (propranolol HCl) is administered to a nursing woman.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. Bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency usually of the Raynaud type.

Central Nervous System. Light-headedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, vivid dreams, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy and vivid dreams appear dose related.

Gastrointestinal. Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic. Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory. Bronchospasm.

Hematologic. Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-immune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. Alopecia, LE-like reactions, psoriasisiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE. At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

REFERENCES:

1. INDERAL LA National Compliance Evaluation Program. Data on file, Ayerst Laboratories.
2. Ravid M, Lang R, Jutrin I. The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985; 145:1321-1323.

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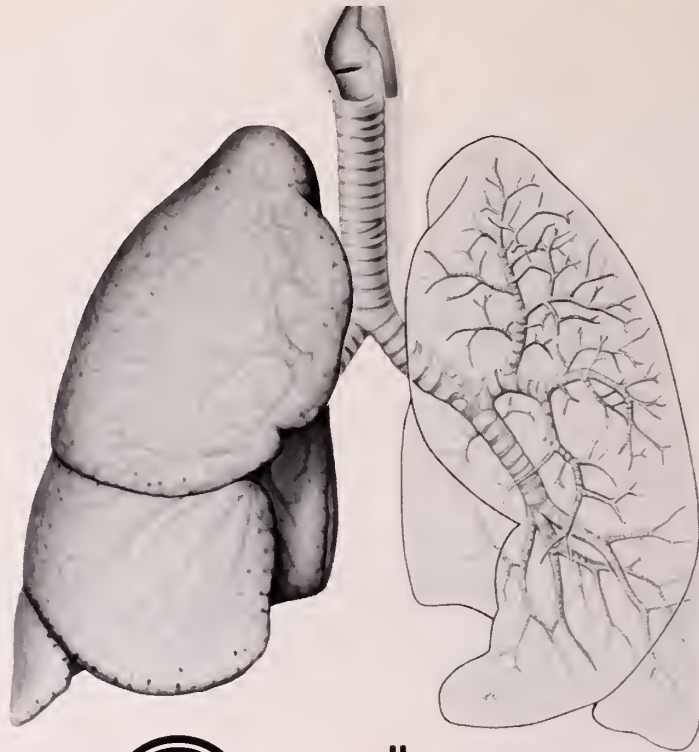


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Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975, 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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PRECAUTIONS:

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Nursing Mothers: It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.

Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

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Revised, April 1982.

5685

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978

2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.

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Yo Ho Ho!

Some of the methods employed to increase the size of a physician's practice are not really new, even though they are currently in vogue. Classic among these popular oldies is the traditional game of pirating patients.

In the interests of educating and orienting our younger colleagues, those men and women who have been in practice less than ten years, I think it only fair to present some of the more common techniques involved in the fine art of pirating patients:

1. You refer, for a specific, appropriate purpose, an established patient to a colleague practicing in a subspecialty. During your patient's visit there, he or she is advised that, in truth and fact, the specialist *does* care for the *whole* patient, encouraging the inference that there is no need for the patient to "traipse all over town seeing a number of doctors," or of course, even bother going back to see the referring physician.

2. In the process of establishing a diagnosis, you refer a patient to a specialist of your choice, one who is acceptable to the patient. Following the determination that the cause of the patient's symptoms is not in the specialty field of the consultant, he or she takes the liberty of referring the patient to yet another specialist, without asking your opinion or preference. Worse, the second consultant is frequently called in without obtaining the patient's consent, opinion, or preference. This technique is particularly irksome (and legally hazardous) when your expertise in the second specialist's field is at least equal to his, and your experience is much greater.

3. You determine that your patient should submit to a procedure that is outside your field of competency and must be done in the hospital. You refer the patient, with his knowledge and consent, to a

consultant who, in turn, concurs with your advice and admits the patient to a hospital. You hear nothing further from the consultant, but a copy of the hospital discharge summary appears in your mail and, reading it, you discover that a second consultant, one practicing in your specialty, was asked to see the patient during the period of hospitalization.

4. A relative of one of your established patients is an established patient of one of your colleagues. Your patient and your patient's relative have some similar and some dissimilar health problems. The relative reports to your patient that your colleague expressed anxious concern, even shock, that you had not obtained an XYZ study and prescribed the much newer and more effective ABC compound. Feigning a concern for propriety, your colleague asks the relative about the state of your patient's health, admitting that you are *supposed* to be a good doctor.

There are, of course, many other ways to pirate patients, and truly new techniques continue to be perfected. Such attractions as the "Large, Multi-specialty Group," the "Controlled Fee Corporation," the "Group Rate Panel," the "Free Screening on Friday" trap, the "Immediate Appointment Clinic," the "World Health Center" misnomer, the "Morning, Noon, Night, Weekend, and Holiday Clinic," and the "Assignments Accepted, Compensation Cases Welcome Clinic" are some of the (poorly) disguised techniques recently designed to pirate patients more efficiently. How effective they are is yet to be determined. How professional they are is a settled issue.

Maybe it's time to change our symbol from the staff of Aesculapius to the Jolly Roger.

—MRJ

First, Do No Harm

In this day and age, it is difficult to acknowledge and integrate the teachings of Hippocrates into the everyday practice of medicine.

I will agree with those who would say that Hippocrates's science of medicine falls woefully short in today's high technology and the wonder of modern medicine; however, like the Ten Commandments, it is difficult, if not impossible, to fault the precepts of Hippocrates's teachings.

With all the rules and regulations that emanate daily from the bureaucrats, how can we really be sure that what we are doing is always in the best interest of the patient?

This great system of medical care in which we labor today was not developed following bureaucratic rules, by explaining the differences as outliers, by treating all patients with the same diagnosis by the same cookbook. No, it was developed by hardworking scientists, hardworking physicians in a labor of love.

Yes, they had peer review, as medicine always has had, but the reviewers were not hamstrung or guided by the unknowing, uncaring hands of people who



made promises, could not keep them, and preferred to blame their failures on others.

How can we best serve our patients?

We must be even more staunch advocates for our patients' health and medical care.

We must educate and alert them to the dangers of the bureaucratic managed medical system now being touted as the answer to the "rising costs of medical care."

We must, at all costs, resist the rationing of needed medical care, regardless of the "noble cause."

And finally, we must be willing to take an unalterable stand to protect this great system of medical care that belongs to the American people.

Over 200 years ago, a small group of men from all walks of life, among them a physician, pledged their lives, their honor, and their fortunes to free their people from the bureaucracies of the day.

It is an interesting thought to contemplate: How many of us today would be willing to pledge even a small part of our fortune to save the freedom of the practice of medicine?

W. J. Rosenthal, M.D.

St John Breast Cancer Screening Clinic: A Twelve-Year Review

HAYS R. YANDELL, MD; RICHARD F. BARBEE, MD; DONALD F. MAURITSON, MD

This article summarizes the 12-year experience in a breast cancer screening clinic and demonstrates how earlier detection might be achieved.

In November of 1974 the authors, a surgeon and two radiologists, established the St John Medical Center Breast Cancer Screening Clinic for the purpose of correlating physical findings with mammography and thermography in the diagnosis of breast disease.

For two years we reviewed the findings together. It was apparent, then and now, that the radiologists could discern densities in the mammogram that could not be identified by palpation, and that the examining physician could feel nodules that could not be identified by x-ray. Actually, the only definite correlations are: (1) obvious, fairly superficial carcinomata over one centimeter in diameter; (2) fibroadenomata in any dimension from "pea-sized" up; and (3) obvious cysts perhaps 2 cm or more in diameter. So called "mammary dysplasia" cannot be diagnosed on manual examination.

The project thus evolved into a breast cancer

detection center located in the Department of Radiation Oncology at St John Medical Center, Tulsa, Oklahoma.

Soon after the establishment of the clinic, the national publicity concerning President Gerald Ford's wife, Betty, and Vice-President Rockefeller's wife, Happy, both of whom underwent mastectomies, resulted in an initial influx of patients.

In the past twelve years, 1974 to 1986, we have examined 2,210 women and 2 men at a clinic held once weekly.

Referrals

The source of most of our patients has been the Tulsa City County Health Department which, until recently, screened hundreds of women for both breast and cervical cancer. It was our pleasure to help train three of their public health nurses in breast examination, and they became expert in detecting breast abnormalities.

Planned Parenthood and Family Planning refer many young women for evaluation and for any contraindication to the birth control pill.

Surrounding county health departments, the American Cancer Society, the University of Oklahoma Tulsa Medical School, and private physicians are other sources.

Address correspondence to Hays R. Yandell, MD, St John Medical Center, 1923 South Utica, Tulsa, Oklahoma 74104

Examination

Initially the patient fills out a questionnaire-type history. This is reviewed with the examiner, with special attention being given to pertinent factors such as family history of breast cancer, reproductive history, present and past use of hormones, and when and how any "lump" was discovered.

We employ the standard methods of inspection and palpation, including the supraclavicular and axillary nodes, so well described by Haagensen¹ and the American Cancer Society's pamphlet on breast self-examination, "How to Examine Your Breasts."

In the sitting position, these methods include inspection for dimpling of the skin, nipple retraction, skin retraction when the pectoral muscles are

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contracted by pressure with the hands on the hips, nipple discharge, and bimanual palpation for subareolar mass. With the patient's arms stretched overhead, we use an additional maneuver of simultaneously passing the flattened fingers from the axillae over the outer aspect toward the undersurface of each breast.

With the patient in supine position with a small pillow under the shoulder and the hand behind the neck, each area of the breast is explored circumferentially with a circular motion of the tips of the flattened forefingers. We also use an additional technique of "fingering," accomplished by simultaneously using the forefingers of each hand as if playing the piano. This is very useful in locating and defining nodules.

If there is discharge from the nipple, the patient is asked to express this by stripping her nipple. The fluid is smeared between two glass slides, sprayed with hair spray, and sent to the cytology lab.

Mammography and Age Guidelines

Our policy in regard to age has been as follows:

We do not order mammography for any person under 35 years of age unless there is a possibility of a cancer, in which case there is no age restriction.

We order a baseline mammogram for anyone 40 years old or older, and advise another at age 45 and age 50 years, unless there is prior indication, or unless the patient falls in the high-risk category, ie, family history of breast cancer, previous surgery including mastectomy for cancer, non-parous women, and those who show moderate to marked dysplastic changes (prominent ductal pattern) by x-ray study.

In the age group 35 to 40 years, we order baseline mammograms for those in the high-risk category as above, women with very large breasts, and those with moderate to severe fibrocystic disease (in order to differentiate from cancer).

For patients older than 50 years, we recommend yearly mammograms. If, however, a patient has had previous negative mammography and is practicing breast self-examination along with annual check-ups, mammography, at the discretion of the examiner, may be performed less frequently.

Imagery

Initially we performed thermography as a screen for younger women, and for women whose breasts were clinically normal. A private grant was available to cover those costs. However, thermography proved to be impractical for our system of one visit, since it was necessary to obtain a mammogram on all of the positive cases and all of the false positives. Therefore, we discontinued its use.

For several years we used only xeromammography. Because of the frequent breakdown of machinery, we switched to low-dosage x-ray mammography, which has the additional advantage of less radiation. Periodic calibrations have shown that, on the average, the whole breast dose for a breast compressed to a thickness of 4 cm was 160 millirads per exposure.²

Sonography is occasionally used to differentiate cysts and solid tumors. It is also possible by x-ray study to estimate the degree of risk of developing breast cancer by the prominence of duct patterns.³

Clinical vs X-ray

In our experience, carcinomata of about 1 cm⁺ are palpable if fairly superficial. Cysts 2 cm in diameter, and fibroadenomata from the size of a pea and up are also palpable. Early Paget's disease can be discovered only clinically.

We find *nodule* a good descriptive term for a discrete mass, and *nodular breast* where there are many indefinite masses as in fibrocystic disease or in changes due to hormonal stimulation. *Thickening*

is a useful and frequently used term but hard to define.

X-ray diagnosis is more precise but not definitive. It has the great advantage of being able to detect microcalcifications and cancers that are too small to feel, when they are in a highly curable state.

Seventy percent of the cases of carcinoma in our series were suspected clinically, and 80% were suspected by x-ray, illustrating the importance of using both modalities plus a biopsy for definitive diagnosis.

Findings

There were 48 cases of malignancy (47 cases of carcinoma and 1 case of cystosarcoma phylloides) in the 2,210 subjects examined. The yield was relatively small for the work involved. The incidence of 2.17% has no significance in our series. On the one hand, a great number of the older patients had been previously screened by public health nurses. On the other hand, a great number of young women under the age of 25 years were referred by Planned Parenthood and Family Planning.

We staged the cases based on pathology: Stage I if the tumor measured 2 cm or less and no metastatic axillary nodes were found in the pathological specimens; Stage II if axillary nodes were involved or if the tumor was over 2 cm even if there were no nodes involved; Stage III if there was advanced local involvement, extensive axillary involvement or both; and Stage IV if there were distant metastases.

With this rather strict staging there were 22 cases in Stage I, 24 in Stage II, 1 in Stage III, and 1 in Stage IV. These figures would indicate that at least 50% of women with malignancy (26 of 48 in this study) already have axillary metastasis when they first consult a physician.

The pathological diagnoses and numbers of each were as follows:

Infiltrating ductal carcinoma	35
Infiltrating intraductal carcinoma	5
Intraductal carcinoma (noninfiltrating)	3
Paget's intraductal	2
Infiltrating lobular carcinoma	1
Medullary carcinoma	1
Cystosarcoma phylloides (age 24)	1
	48

Fifteen of these cases came directly to the clinic or were referred by physicians. Twenty-eight were sent by the Tulsa City County Health Department.

In the cancer group, the youngest patient was 27

years old and the oldest was 93. The average age when diagnosed was 60 years.

The size of the cancer varied from 1 cm (3 cases) to 7 cm. At least 5 cases were multicentric.

Disposition

All patients, unless they had been previously instructed, were taught breast self-examination (BSE) and given the pamphlet published by the American Cancer Society.

They were referred back to the referring agency or physician and were seen on a one-visit basis unless a recheck examination was thought advisable because of something found on the examination or on the mammogram.

There is a need
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Patients requiring any type of surgery, whether for biopsy, excision of benign tumors, or mastectomy, unless they had their own surgeon, were referred to a surgeon competent in breast surgery. Many were referred to whomever was serving as chief of surgery at St John Medical Center at the time.

Of the 48 cases of malignancy, all Stage I and Stage II cases had some form of mastectomy — partial, simple, modified, or radical. Two cases, Stage III and Stage IV, had only biopsies.

In the 7 years since 1979, only one radical mastectomy among the 24 cases of cancer was performed, reflecting the national trend to more conservative surgery, whereas 16 of the first 24 cases through 1979 had radical mastectomies.

Discussion

We had hoped as time went on that we would detect more Stage I and minimal cases, but of the same number of cases during the first 6 years and the next 6 years, oddly, there were 11 Stage I and 12 Stage II cases in each group.

Of the 2,210 patients examined, statistically 151 more will develop breast cancer during their lifetime (9%⁴ of 2,210 = 199 less 48 in this study = 151). These patients, having been screened and taught

BSE, are aware of the problem and will, it is hoped, seek early treatment.

Because of the relatively small number of cases of cancer in this series and the small number of ten-year follow-ups possible, any study of survival rate at this time would not yield significant results.

Conclusions

Breasts come in all sizes, shapes, consistencies, and appearances. No two pairs are the same. The differences are determined by age, heredity, pregnancy, menstruation, hormones, disease, augmentation and reduction mammoplasties, silicone injections, and even tattoos.


Both clinical examination (including history, inspection, and palpation) and mammography are essential in diagnosing breast cancer short of a biopsy. A biopsy should be performed if there is a suspicion of cancer on examination or by x-ray.

These generally known techniques, as outlined, if more widely practiced upon the female population, might partially approach the salvage record of the Pap smear in cervical cancer by salvaging a greater number of early cases of breast cancer.

There is a need for even more public education stressing the advantages of early detection and treatment rather than the frightening figures of incidence and mortality.

Screening is readily sought by the public and is helpful, rather than competitive, to the medical practitioner.

Nurses trained in breast examination are a great resource in any screening project.

If screening as described were done routinely for women over the age of 35 or 40 years by their own practitioners or in clinics, there probably would be thousands of additional early cases of breast cancer detected. 

Acknowledgment: This study was made possible by the Department of Radiation Oncology, St John Medical Center, Tulsa, Oklahoma, who housed the project, their personnel, and by Fern Bowles, RN, who assisted in the examination of most of these patients.

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Legionella pneumophila Infections in Oklahoma: Prevalence Among VA Hospital Patients Prior to the 1976 Philadelphia Outbreak

PEGGY J. GUTHRIE, PhD; STANLEY L. SILBERG, PhD; CHARLES H. LAWRENCE, PhD

The results of our survey suggest that the *L pneumophila* infection rates in Oklahoma are high but have not changed significantly since the "new" pathogen was first described, and that the role of the organism in unidentified pneumonias in Oklahoma could be much more significant than has been recognized.

During the past 10 years, the recognition of *Legionella pneumophila* as a causative factor in acute febrile illness has been steadily increasing. Even though the organism was not identified until after the outbreak of pneumonia among Legionnaires attending a convention in Philadelphia in 1976,¹⁻³ retrospective studies have indicated several prior epidemics and endemic episodes.

According to McDade et al,⁴ the unidentified organism was first isolated by Jackson in 1947, and according to Osterholm et al,⁵ the first outbreak attributable to the still unidentified bacterium occurred in 1957. The organism was subsequently implicated as the etiologic agent responsible for an outbreak of pneumonia among psychiatric patients in Saint Elizabeth's Hospital in 1965, and for a nonpneumonic form of the disease among visitors

and employees at the Pontiac County Health Department in 1968.^{7,8} The nonpneumonic form was also identified by Fraser et al⁹ as the cause of a 1973 outbreak among men who cleaned steam turbines, and Terranova et al¹⁰ attributed the pneumonic form to a 1974 epidemic at an Odd Fellows convention in Philadelphia at the same hotel that was to host the now famous Legionnaires convention two years later. Long-term retrospective studies of stored serums from pneumonia patients in Iowa¹¹⁻¹³ and Seattle¹⁴ have also indicated the existence of the organism and the occurrence of clinical disease prior to 1976.

All of the above studies, however, focused only on the coincidence of Legionellosis in study groups preselected according to clinical disease, primarily pneumonia, thereby negating determination of the prevalence of *L pneumophila* antibodies in other, more general population groups. The purpose of this investigation, which is the third in a series of studies of inapparent *L pneumophila* infections in Oklahoma, was not to establish that the organism or the disease existed prior to the 1976 Philadelphia outbreak which provided its name, but rather to add to the body of knowledge concerning the historical and geographical pattern of *L pneumophila* infections and to provide a base for better interpretation of more recent environmental and seroepidemiologic studies.

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Methods and Procedures

Serum samples from 99 Oklahoma residents who had received hospital treatment between January 1968 and April 1976 were provided by the Veterans Administration Hospital in Oklahoma City. Since these individuals presented a variety of health conditions, it could not be assumed that they represented a healthy population; however, since they were not preselected according to diagnosis, age, or geographic origin, it could be assumed that their

**Many cases
of legionellosis
may still
remain unidentified
in our hospitals today.**

serology pattern was representative of a large segment of the population of Oklahoma.

Sex and age (where known) of the patients and the date of collection were recorded for each serum sample prior to storing it at -20°C from the time of hospitalization of the individual to the analysis of the sample. The study group included 93 males and 6 females, and represented an age range of 25 to 80 years for the 80 patients whose ages were recorded.

The indirect fluorescent antibody (IFA) procedure recommended by Wilkinson et al,¹⁵ modified by CDC,¹⁶ and described by Guthrie et al¹⁷ was employed to determine antibody titers. A titer equal to or greater than 1:64 was considered a positive serologic

test for IFA antibodies to *L pneumophila*, and the corresponding patients were regarded as being infected but not necessarily as having clinical disease.

Results

Table 1 shows the distribution of serum IFA levels for *L pneumophila* serogroups 1, 2, 3, and 4 among VA Hospital patients whose exposure to the agent occurred prior to 1976. Of the serums tested, the overall prevalence of infection was 39.4% with a range from 14.1% at 1:64 to 5.1% at 1:2048.

Since the small number of female patients available to the study precluded any analysis by sex, all data were pooled for the analysis by age group. As shown in Table 2, the percentage of antibody titers $\geq 1:64$ increased from 44.4% in the <45 year age group to a maximum of 54.5% in the 45-to-54 year age group before decreasing again in the higher age groups.

Table 1. — Distribution of Positive Antibody Titers to *Legionella pneumophila* Among 99 Oklahoma VA Hospital Serums Drawn in the Years 1968-1976

Antibody Titers	Seropositives*	Prevalence Rate, %
1:64	14	14.1
1:128	13	13.1
1:256	4	4.0
1:512	1	1.0
1:1024	2	2.0
1:2048	5	5.1
Total	39	39.4

*Individuals were considered seropositive (infected) at antibody titers $\geq 1:64$

Table 2. — Distribution of Antibody Titers to *Legionella pneumophila* Among 80 Oklahoma VA Hospital Serums Drawn in the Years 1968-1976, by Age

		Age Groups			
Antibody Titers		<45	45-54	55-64	>64
# surveyed	<1:16	5	3	9	6
%		55.5	13.6	36.0	25.0
# surveyed	1:16	0	4	4	6
%		0	18.2	16.0	25.0
# surveyed	1:32	0	3	4	3
%		0	13.6	16.0	12.5
# surveyed	1:64	2	5	2	2
%		22.2	18.2	12.0	8.3
# surveyed	1:128	2	4	3	2
%		22.2	18.2	12.0	8.3
# surveyed	1:256	0	0	2	2
%		0	0	8.0	8.3
# surveyed	1:512	0	0	0	1
%		0	0	0	4.2
# surveyed	1:1024	0	1	1	0
%		0	4.5	4.0	0
# surveyed	1:2048	0	2	0	2
%		<u>0</u>	<u>9.1</u>	<u>0</u>	<u>8.3</u>
Total serums collected*		9	22	25	24
Total positive [†] (≥1:64)		4	12	8	9
% positive		44.4	54.5	32.0	37.5

*80 of the total 99 serums had age information

[†]Titers $> 1:64$ were considered seropositive (infected)

Kruskal-Wallis. $H_{(3)} = 3.69$, $p = 0.03$

Temporal analysis of the data (Table 3) indicates that for the years in which nine or more individuals were sampled, the prevalence rate varied from 20% in 1972 to 60% in 1973, with no apparent long-term pattern. Stratifying by month of serum collection (Table 4) indicates a bimodal distribution with the highest rates occurring in May (66.7%) and December (85.7%), and the lowest rate (10%) being observed in August.

Discussion

Both the distribution of antibody titers and the overall prevalence rate of legionella infection observed in this study are comparable to those found in a later investigation of 500 healthy blood donors from the same geographical area.¹⁷ This suggests that the exposure of the VA Hospital patients was not atypical. Although age differences were not statistically significant in the present study, the pattern of seropositive serums versus age group is the same as was observed for the blood donors and supports the observation that the exposure experience of the VA Hospital patients was not atypical. Collectively, these two studies indicate that *L pneumophila* infections have been and continue to be common in the Oklahoma population, but apparently the prevalence rates have not increased since this "new" organism was first identified.

Conclusions drawn from the seasonal trend of seropositive serums should be done cautiously since the data were identified by time of serum collection rather than by actual or estimated time of exposure; however, it is interesting to note that the higher of the bimodal peaks (4th quarter) follows the annual

peak of pneumonias in Oklahoma. This suggests that legionellosis could constitute, or at least be a significant co-factor, in the overall number of pneumonias, especially among those cases whose etiology is unknown. The occurrence of the lower bimodal peak during the late spring and early summer suggests that *L pneumophila* could also be a significant factor in the causation of spring and summer pneumonias in the geographical area studied.

If single serum titers $\geq 1:256$ were considered as serodiagnostic evidence for recent clinical disease, then 30.8% of the seropositives, which represents 12.1% of the total number of patients studied, would have had unrecognized legionellosis. Since seroconversion may not occur for two weeks after infection, many cases of legionellosis may still remain unidentified in our hospitals today. It was this concern that prompted the present investigators to initiate a current study of the role of *L pneumophila* in unidentified pneumonias among VA Hospital patients in Oklahoma.



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(continued)

Table 3. — Distribution of Infection to *Legionella pneumophila* Among 99 Oklahoma VA Hospital Serums, by Years of Serum Collection

Year	Titer	Number of Seropositives*	Total Surveyed	Prevalence Rate, %
1968	<1:64	0	4	0
1960	1:64-1:2048	11	26	42.0
1970	1:64-1:2048	9	22	40.9
1971	1:128-1:512	2	4	50.0
1972	1:64	2	10	20.0
1973	1:64-1:256	6	10	60.0
1974	1:64-1:2048	5	9	55.6
1975	1:64	4	10	40.0
1976	<1:64	0	4	0
Total	1:64-1:2048	39	99	39.4

*Seropositive (infected) was considered as antibody titers $\geq 1:64$

Table 4. — Distribution of Infection to *Legionella pneumophila* Among 99 Oklahoma VA Hospital Serums, by Month of Serum Collection

Month	Number of Seropositives*	Total Surveyed	Prevalence Rate, %
January	3	10	30.0
February	4	9	44.4
March	6	13	46.2
April	6	12	50.0
May	2	3	66.7
June	1	6	16.7
July	2	7	28.6
August	1	10	10.0
September	5	13	38.5
October	2	7	16.7
November	1	2	50.0
December	6	7	85.7
Total	39	99	39.4

*Seropositive (infected) was considered as antibody titers $\geq 1:64$

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Coming in September . . .

Manuscripts being considered for publication in September include a study of education's impact on cephalosporin prescribing practices and a case report on leiomyoma of the fourth part of the duodenum. Already scheduled is a report on AIDS from the AMA Board of Trustees.

Dare to Be Intimate

DALA R. JAROLIM, MD

Originally an address to a group of Tulsa medical students, this message is for practicing physicians everywhere.

This week's *New England Journal of Medicine* titles include "Practicing Medicine in the New Business Climate," "A Hard Look at Cost Containment," and "The Counterrevolution in Health Care Financing." Over the last five to seven years these topics have moved to the forefront of medicine. It's a business, requiring cunning, savvy, financial wizardry; words that have never been applied to physicians. In fact, just the opposite terms endear the doctor to his patients: trusted, respected, compassionate. I am concerned that you young doctors who are being raised on the diet of commercialism may be less acquainted with the intimacy of medicine than your elders, and that is too precious a gift to lose. Your presence here symbolizes your intellectual acumen, yet what I'm hoping to evoke from you cannot be learned from a textbook; it comes with experience and self-exposure. One patient at a time. My talk tonight focuses on private, special

moments with patients and ways one can grow from them.

At some point in your third or fourth year, most of you become doctors, thinking, feeling, looking, and acting like physicians. The overwhelming emotion at this stage as I remember is fear. Fear of not living up to the new image, fear of not knowing, fear of doing something stupid, fear of injuring a patient. How many of you have dreaded going in to do that next work-up? Maybe you were tired, missing a meal, or sick, or maybe you were plain scared of a patient encounter. *Doing* a rectal examination is much different from *reading* about it in a book. We've all been there.

Yet, wait til your fear of injuring someone is twisted into *guilt* when you do. My first day as an MSIII was on pediatrics, and it qualifies as a full-fledged nightmare. I was told to go and start an IV on a 7-year-old named Tommy and administer vincristine for his leukemia. Just like that. And "if it burns, you know you're out of the vein." Well, I was out of the vein and no, it didn't burn, but yes, most of the dorsum of the child's hand sloughed off. Had he lived, he would have required skin grafting. As it was, he *just* had a lot of pain before he died. Pain that I inflicted, right? Wrong. MSIII's aren't supposed to do technical procedures *alone*, and our team

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**We doctors perceive ourselves as determined people.
After all, it takes a lot of effort
to get into and stay in medical school.
But are we that unique?**

concept is intended to prevent these kinds of mishaps. So I went on to overcompensate, to become an oncologist and administer vincristine — and worse — daily. The right way.

We talk about medical training as the last sweatshop. We go for hours without sleep, go from the clinic to the hospital ward to the emergency room to the code blue to whatever is required. We grumble and complain, but proceed because it is expected, knowing there's a light at the end of the tunnel. We think that we are masters of endurance, superpersons.

A patient named Nancy has showed me what real endurance is. Nancy at age 21 while water skiing developed a "catch" in her knee, which soon became very active rheumatoid arthritis. Now, at age 43, after thousands of pills, gold injections, surgeries, and chemotherapy, she has pain with every step, chronic debility, and deformity. There is no cure, no improvement, no end in sight. Yet she is a top real estate producer; devoted wife, mother, and grandmother; and active in church and community. Nancy endures that of which we in good health have no idea.

We doctors perceive ourselves as determined people. After all, it takes a lot of effort to get into and stay in medical school. But are we that unique? Melinda was 39 years old, a nursing supervisor and the mother of two when she decided to have bilateral mastectomies and reconstruction for severe fibrocystic disease. Unfortunately, an occult breast cancer already metastatic to lymph nodes was found, but only created a temporary obstacle for this determined young woman. In a six-month period she had her reconstructions done; she planned her chemotherapy and self-administered it at home on the weekend so as not to miss any days of work; she cared for her family; she attended night school and completed her master's degree with a four-point average. Her determination was awesome.

The *positive* feelings of patient interactions are

often minimized, and particularly so in patients with chronic or terminal illness. They are powerful, often overshadowing any other aspect of the patient's course. I'm here to champion these glad feelings, to cultivate and nourish them, for they are the weapons to fight burnout and depression, midlife crisis, and substance abuse in the health professional.

Margaret and Paul, ages 84 and 94 years respectively, came to me as a couple for primary care. They don't share a common chart, but might as well. They share an exam room and appointment times and are truly a unit. Paul's original and recurring complaint was that his erections were not what they were before his aortic aneurysm surgery! Margaret, who is cured of Hodgkin's and recently post-coronary artery bypass graft, has as her personal goal only to live in good health in order to take care of Pappy (as she calls him), and Pappy plans to live forever if he can just get his sex life back up to expectations. They are truly a study in the joys and adventure of aging. I hope to emulate them.

Walter was 25 years old when I met him. He had newly diagnosed chronic granulocytic leukemia present for an unknown length of time. His life expectancy was around three years. He was recently engaged and planning his wedding and didn't really think his disease meshed with his plans very well. Nor did we. We wanted him cured, not dead. The only hope for cure was to replace his cancerous bone marrow with an identical sibling match, which he was lucky enough to have. At that time this procedure had never been done for anyone with Walter's stage of disease.

We had a tough choice: Do we advise him to have a transplant early, risking immediate death from graft rejection, opportunistic infection, or graft vs host disease, but with the possibility of a cure; or do we wait and treat conventionally, knowing he would likely live for three years but sentencing him to certain death? These agonizing decisions can be

**When you personally make a decision
or perform a procedure that beats the odds and
helps save a person's life, you too will know my ecstasy. . . .
Enjoy!**

discussed with those who are consulting and certainly with the patient, but I found out that in the end it is the very lonely responsibility of the main doctor in the doctor-patient relationship to decide.

I'm a go-for-it type person and advised Walter the same. He did, did beautifully, and 7½ years later is free of leukemia, working, married, and alive. When you personally make a decision or perform a procedure that beats the odds and helps save a person's life, you too will know my ecstasy. Each of you will be making these decisions next year, and the rewards are tremendously gratifying. Enjoy!

People ask me daily how I care for cancer patients and deal with such a "depressing" specialty. I go through the usual routine: that one can set short-term palliative care type goals which can be reached, give the patient some control over his illness/treatment, provide pain control and moral support. Actually, these patients provide me with much happiness and positive reinforcement. Most of them accept their illness and many exhibit a life-enhancing sense of peace.

The queen in this category was Bettie, a Christian minister with breast cancer. Bettie knew for three years that she had metastatic disease and that her days were numbered. She didn't refuse treatment but managed to travel to see good friends and enjoy time with God and nature around her chemotherapy appointments. All the while she was getting rid of earthly possessions, saying good-byes, and collecting butterflies. Some view the butterfly as a symbol of new life, life after death, or immortality. Bettie's room was full of them, gifts from all who knew her. Many months into her last illness, with her bones full of cancer and her blood full of morphine, Bettie heroically stepped into the pulpit for the last time as a guest minister at the church across the street from mine. She tripped on a cord as she climbed the steps, recovered her balance in agony, and proceeded to speak. It sounded good,

though I was so angry at whatever clown left that cord in her path that I couldn't really listen to her words.

Bettie's peace knew no bounds. The last time I saw her in the nursing home she was in a coma, with a smile on her face. Three days later she died, on a night in April when tornadoes hit all over town. Trees were down on all the major access roads and kept me from going out. Yet, Bettie was untouched by the destruction. She, like the eye of the storm, was always an oasis of peace.

I have told you my stories, in part as a DRG, HMO, PPO, and Medicare diversion. Medicine as I knew it during my training and early years is gone. More and more of your time will be spent seeing less and less of your patients. Your concerns will be with securing funding for treatment, filling out forms justifying need for treatment, documenting that you're giving the absolute best state-of-the-art treatment while spending the absolute least money, practicing good medicine so as to keep the malpractice lawyers at bay, and all for less and less money. The primary motive, the crucial reason why one would even consider these constraints, lives in the patient and can be nourished by your relationship with him or her. Never forget that is why we exist. We can expect a wealth of gratification, pleasure, and insight from these people, our patients, who trust us with so much — the quality of their lives and the dignity of their dying. Do we dare *not* be intimate?



Dala R. Jarolim, MD, is a member of the full-time faculty at the University of Oklahoma Tulsa Medical College. A 1975 graduate of the University of Oklahoma College of Medicine, she is board certified in internal medicine and in medical oncology.

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Hawaii or the Bahamas?

T. V. VENKATARAMAN, MD

The other day I called my physician friend's office to have my blood cholesterol checked. I was feeling fit as a fiddle, but it had been years since I had my blood checked.

The secretary answered the phone, and when I explained that I needed my blood cholesterol checked, she said the doctor would call me back.

Soon the phone rang.

Dr Deal: "John, I hear you want your blood cholesterol checked. That's a fine idea. Now tell me, where do you want to go to have the blood checked? The Bahamas or to Hawaii?"

I was taken aback. I hadn't planned on a vacation and probably couldn't afford one.

Me: "Doc, I wasn't planning on any vacation. I was just going to drop by your office and have the blood checked."

Dr Deal: "John, I'm not talking about you taking a vacation. I'm talking about our 'cholesterol special' package that we are offering this month. You see, if you have your blood

checked this month, we'll fly you to either the Bahamas or Hawaii, pay for four nights' stay in an oceanfront condominium, and you could have your blood test done there on the trip."

It sounded too good to be true.

Me: "Doc, are you serious? You mean I can go to Hawaii or the Bahamas for just the price of a blood test?"

Dr Deal: "Sure. Listen, I wouldn't promise you something I couldn't deliver. Let me ask you this: Why are you having your cholesterol checked? I'll bet you're worried about your heart or about colon cancer. Statistically, more of us die of heart attacks or colon cancer. That's why I am offering this deal through a drug company promotion.

"If your cholesterol is elevated, you can have coronary artery bypass surgery or a free colonoscopy while in Hawaii or the Bahamas."

Me: "Doc, I don't have any heart problems or any trouble with my colon. I'm pretty regular."

Address correspondence to T. V. Venkataraman, MD, Classen Professional Building, 1110 N. Classen, #200, Oklahoma City, Oklahoma 73106.

Dr Deal: "John, prophylactic bypass surgery is now the 'in thing' in medicine. What we want to do is avoid heart attack, not wait for it to happen.

"Look at our President; do you think he would be here with us today, negotiating for Star Wars, if he didn't have his colon checked each year? The statistics are overwhelming, John, they are."

I stood thinking for a while.

Me: "Doc, you said four nights' stay. What happens if I'm not ready to be discharged after the test or operation? What if the incisions are not healed?"

Dr Deal: "No problem, John. Tell me, do you still have your appendix or tonsils? We'll throw in a free appendectomy or tonsillectomy to justify your extra stay."

All this was overwhelming. I paused.

Me: "Dr Deal, I forgot to mention. I just changed jobs and don't carry any medical insurance."

Click. The phone went dead. I was disappointed. Two minutes later the phone rang again. It was Dr Doe's secretary.

Secretary: "Mr Bloke, I just heard you are in the market for a blood cholesterol check. Let me tell you about our 'Carribean Cruise - Cholesterol' package."

All this was too much for me. I left the receiver off the hook. It was getting late for my jogging. ☐

T. V. Venkataraman, MD, is an assistant clinical professor of medicine at the University of Oklahoma Health Sciences Center. He is board certified in nephrology and internal medicine.

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Newborn Eyecare

Ophthalmia neonatorum, acute conjunctivitis in the newborn infant, continues to be a problem in Oklahoma. While in the past gonococcal ophthalmia was the most common problem, chlamydial conjunctivitis now is recognized as the most common cause of neonatal eye infections. From 18% to 50% of infants born to infected mothers will have chlamydial conjunctivitis between one and three weeks after birth. Chlamydia is also the most common cause of afebrile interstitial pneumonia in infants under six months of age and is associated with a slight increased risk for otitis media and bronchiolitis. In the United States, the prevalence of reported cervical chlamydial infection among pregnant women in most studies is approximately 8% to 12%.

In Oklahoma, neonatal prophylaxis of the eyes is required by law. In the past, when gonococcal ophthalmia was recognized as the major problem, silver nitrate was an effective prophylactic agent. However, silver nitrate does not prevent chlamydial disease and frequently causes chemical conjunctivitis. Currently, with the increased prevalence of chlamydial conjunctivitis, use of erythromycin (0.5%) ophthalmic ointment has the advantage of being effective in preventing both gonococcal and chlamydial ophthalmia and does not cause conjunctivitis. Tetracycline (1%) ophthalmic ointment also appears to be effective against both gonococcal and chlamydial ophthalmia.

For additional information regarding newborn eyecare, see *MMWR*, Vol 34, No 3S, or contact the Pediatric Division, Oklahoma State Department of Health, 405/271-4471.



DISEASE	May 1987	TOTAL TO DATE		
		This Year	Last Year	5 Yr. Avg.
AMEBIASIS	1	3	4	5
CAMPYLOBACTER INFECTIONS	23	67	81	—
ENCEPHALITIS, INFECTIOUS	1	9	6	10
GIARDIA INFECTIONS	13	57	67	—
GONORRHEA (Use ODH Form 228)	776	4179	5236	5241
HAEMOPHILUS INFLUENZAE INVASIVE DISEASE	15	63	99	—
HEPATITIS A	21	120	132	195
HEPATITIS B	24	97	69	85
HEPATITIS, NON-A NON-B	2	12	20	—
HEPATITIS UNSPECIFIED	1	13	23	59
MEASLES (RUBEOLA)	0	1	10	3
MENINGITIS, ASEPTIC	12	26	21	22
MENINGITIS, BACTERIAL (non-meningococcal, non H. Influenzae)	3	21	29	30
MENINGOCOCCAL INFECTIONS	1	14	13	16
PERTUSSIS	2	29	24	51
RABIES (Animal)	5	12	28	58
ROCKY MOUNTAIN SPOTTED FEVER	15	19	21	21
RUBELLA	0	0	0	0
SALMONELLA INFECTIONS	46	114	139	114
SHIGELLA INFECTIONS	13	79	59	82
SYPHILIS (Use ODH Form 228)	22	74	73	80
TETANUS	0	0	0	0
TUBERCULOSIS	18	88	97	111
TULAREMIA	2	5	2	4
TYPHOID FEVER	1	2	1	1

Diseases of Low Frequency	Total to Date This Year
ACQUIRED IMMUNE DEFICIENCY SYNDROME	23
BRUCELLOSIS	2
LEGIONNAIRES DISEASE	7
MALARIA	2
REYE SYNDROME	0
TOXIC SHOCK SYNDROME	6

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Supervised Medical Doctors

Some MDs to become SMDs under new state law

Effective July 1, 1987, some Oklahoma physicians will be designated SMDs instead of MDs, according to HB 1478 signed by Governor Henry Bellmon.

Residents, interns, graduate medical students, and other persons who hold the academic degree of Doctor of Medicine but have not yet qualified for unlimited state licensure and practice under supervision will be designated Supervised Medical Doctors (SMD).

Fully licensed physicians will continue to be identified by the familiar prefix *Dr* and suffix initials *MD*.

"The benefit of this legislation is to clearly identify to the public the professional qualifications or the limited status of their physician," commented Carole Smith, administrator of the Oklahoma Board of Medical Licensure and Supervision.

The legislation authorizes the board to establish the exact manner of designation and identification to be used by an SMD on stationery, name tags, prescriptions and other representations to the public.

Each Supervised Medical Doctor will receive from the board a certificate enumerating his limited status and the time period during which he will hold that limited status.

The SMD status will apply to an individual only for the term prescribed by the board. House Bill 1478 limits the time a person may carry the SMD designation to no longer than 25 total, but not necessarily continuous, months.

"The Board will meet in September 1987 to enact the rules and regulations to fully implement House Bill 1478," said Mrs Smith. A public hearing was to be held by the board staff in July to receive comments and input from the public.

HB 1478 does not apply to osteopaths, chiropractors, optometrists, podiatrists, or dentists.

For further information or clarification contact Carole Smith at (405) 848-6841.

A complete copy of the actual language of HB 1478 relating to SMD certification follows:

SECTION 19. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 495f of Title 59, unless there is created a duplication in numbering, reads as follows:

All persons holding the degree of Doctor of Medicine and using that degree as a criterion for their employment, continuing education, or professional training but who have not obtained or maintained regular licensure will be under the jurisdiction of the Board and may be designated as Supervised Medical Doctors (SMD).

Such persons employing the term Doctor or the suffix MD in connection with their name will in all circumstances clearly designate their supervised status.

The manner of designation may be determined as prescribed by the Board.

Such SMD status shall not be applied to any individual for more than a period of time prescribed by the State Board of Medical Licensure and Supervision to not exceed twenty-five (25) total, but not necessarily continuous, months.

All individuals designated as Supervised Medical Doctors will function in compliance with the directions of the Board and will be under its full jurisdiction as evidenced by a certificate issued by the Board.

Evidence of certification as a Supervised Medical Doctor (SMD) will be issued by the Board at its discretion and in accordance with its requirements. Such certificate must be in the possession of each such Supervised Medical Doctor as directed by the Board.

Applications on Board forms and with the applicant paying fees as set by the Board will clearly indicate an intent to register for this designation. Pending approval by the Board en banc at a regularly scheduled meeting, issuance of a certificate as an SMD may be at the discretion of the Board secretary.

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OSMA President M. Joe Crosthwait, MD, (center) stands with other state association presidents during their formal presentation to the AMA assembly.

AMA convention in June draws MDs to Chicago



Representing the OSMA Young Physicians Section at the AMA Annual Meeting are Delegate Robert C. Wright, MD, Stillwater, and Alternate Delegate Garry Pohoretsky, MD, Oklahoma City.



John B. Nettles, MD, Tulsa, delegate from the American College of Obstetricians and Gynecologists, takes notes in the House. Behind him are M. Joe Crosthwait, MD, Midwest City; Floyd F. Miller, MD, Tulsa; and Victor L. Robards, Jr., MD, Tulsa.



Delegates James B. Eskridge III, MD, and Perry A. Lambird, MD, of Oklahoma City, confer.



Michael J. Haugh, MD, Tulsa, listens to the speaker while Orange M. Welborn, MD, Ada, refers to his handbook.

Orthopedist William A. Grana, MD

OKC surgeon heading medical team at Pan American Games

Oklahoma City orthopedic surgeon William A. Grana, MD, is the chief physician for the American teams at the Pan American Games being held this month in Indianapolis.

Dr Grana heads a team of five physicians and at least 25 other medical professionals including trainers and therapists. He will be in Indianapolis for almost a month, including preparation time, the games, and post-event activities.

Dr Grana was the physician with the gymnastics and cycling teams last year in Houston at the US Olympic Sports Festival and was a team physician in February 1985 in Cortina, Italy, at the Winter World University Games. He will also be on the physician team for the 1988 Olympics in Seoul, South Korea.

"As an orthopedist specializing in sports medicine, I have a particular interest in these games," he says. "I've done a tremendous amount of research into sports injuries and particularly how to

prevent them, so it's invaluable to me to be able to see and treat these sports injuries incurred by some of the finest athletes in the world, then see if we can prevent them from happening again."

Dr Grana says it will be his responsibility to determine if it is medically safe for an injured athlete to continue competing.

Another responsibility for the medical team this year is to make certain all athletes are informed about the drug policy — which drugs are legal and which are not.

"Many athletes aren't aware that over-the-counter medications, especially cold medications, contain antihistamines and decongestants that can increase heart rate and ultimately be extremely dangerous," says Dr Grana. "And of course, anabolic steroids are banned completely."

Medical personnel will be on-site at each of the games' 31 sports venues, and Dr Grana and his team will be on call 24 hours a day during the competition.

The team's work began, however, when the athletes first arrived in Indianapolis around July 29. Complete physical examinations, medical screenings, and evaluations were completed for every athlete before competition began on August 7. The games will continue through August 23. □

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Hospitals in crowded markets charging more per admission

Competition among hospitals may increase rather than decrease costs for patients, suggests a report in the *Journal of the American Medical Association*. National hospital data from 1982 show that hospitals in the most competitive markets had 15% higher average costs per patient-day than hospitals with no nearby competitors.

"After controlling for wage rates, patient case mix, state regulatory programs, and hospital teaching role, average costs per admission were found to be 26% higher in hospitals in the most competitive markets (more than ten hospitals within a 24-km radius) than in hospitals with no competitors within a 24-km radius," say James C. Robinson, PhD, of the School of Public Health, University of California, Berkeley, and Harold S. Luft, PhD, of the Institute

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Hospital competition (continued)

for Health Policy Studies, School of Medicine, University of California, San Francisco.

The researcher studied 1982 data from 5,732 US nonfederal general hospitals. They say their study is the first to document the influence of hospital competition on costs for all US community hospitals during the period just before implementation of Medicare's prospective payment system. "The greater economic stress of (this system) for hospitals in more competitive areas will be magnified if nonprice competition takes the form of difficult-to-reverse commitments to costly clinical technologies," the report notes.

Most discussions of market-oriented cost-control programs ignore the importance of nonprice competition, the researchers say. Such competition is demonstrated by the addition of attractive options for patients, such as birthing suites; and also by the offering of amenities to physicians, such as convenient parking, office space, and clerical services. Actions taken to enhance the perceived quality of care add substantially to costs, the researchers say. "Nonprice marketing strategies raise overall costs and at least partially offset the gains in efficiency that result from price competition," they observe.

Price competition works best to lower costs when the consumer can readily compare the quality of products, the researchers point out. Nonprice competition becomes more important when quality is less easily determined. "Hotels, banks, and automobile manufacturers emphasize the comfort, security, and reliability of their products as well as their economy," they say, adding: "It is difficult to imagine a product the quality of which is more a source of consumer concern and consumer uncertainty than hospital care." □

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Risk factors unclear

Anesthesiologists and GPs at greatest risk for impairment

Certain medical specialists appear more likely than others to abuse alcohol or drugs, finds a report in the *Journal of the American Medical Association*, but determining the contributing risk factors will require more study.

The report by G. Douglas Talbott, MD, of the Medical Association of Georgia's Impaired Physicians Program, Smyrna, Ga, and colleagues say risk factors for chemical dependence among doctors are not clearly defined. Precise estimates of the incidence of physician impairment "cannot be obtained," they add.

The study looked at the specialties of 1,000 doctors assessed under the medical association's impaired physicians program between 1975 and 1986 and compared this with the specialty distribution for all US physicians. Of the 1,000 physicians studied, 92% were diagnosed as chemically dependent.

Two specialties, anesthesia and family/general practice, were overrepresented in the sample. The anesthesiologists in the study were more likely than other specialists to abuse narcotics, while most impaired family and general practitioners abused alcohol. The anesthesiologists were younger than others studied; the impaired family/general practitioners were older, more likely to have a solo practice and be from a rural area.

The authors say anesthesiology "has acknow-

ledged chemical dependence to be a major occupational hazard" and makes the greatest effort to detect abuse. The basis for the apparent higher risk in family/general practice is unclear, the study says, but "the nature of the practice and the unique stresses associated with the specialty" may be involved.

The link between physician impairment and choice of a specialty appears not to be casual, the authors say, but may be indirectly or directly associated with predisposing factors. They urge further study of this relationship.

Factors that do appear to play a role in impairment, the study says, include genetic predisposition and environmental exposure; stress and poor coping skills; lack of education about the kinds of impairment that affect a physician's ability to practice; drug availability in a permissive professional and social environment; and denial.

Early detection and treatment seems to be the most effective means of prevention, the authors conclude. They suggest each medical specialty, especially those with apparent excess risk, study the particular factors that may contribute to the problem and share this information with others. Uniform data collection and an information clearinghouse would help greatly, they say.



National Eye Care Project

Hotline helps state's elderly find care, prevent blindness

In a public service program sponsored by the state's eye physicians and surgeons, a total of 32 elderly Oklahoma residents have been examined and treated for diabetic retinopathy.

The program also has uncovered more than 634 cases of cataracts, 61 cases of glaucoma, and 135 cases of macular degeneration — serious eye diseases that in many cases can lead to blindness.

The National Eye Care Project is sponsored by the Foundation of the American Academy of Ophthalmology and the Oklahoma State Society of Eye Physicians and Surgeons. Begun in March 1986, it is designed to bring needed medical eye care and information to the nation's disadvantaged elderly.

More than 3,100 Oklahoma residents have called the project's toll-free Helpline, 1-800-222-EYES. Nationwide, more than 185,000 people have dialed the Helpline number.

According to the American Academy of Ophthalmology, diabetic retinopathy is one of the most treatable eye diseases. Yet, it often progresses to blindness because many people with diabetes fail to seek medical eye care.

"The elderly often feel that nothing can be done to prevent blindness, or they lack the financial resources to seek needed treatment. We're working to remove these obstacles," says Dr Charles A.

(continued on p 603)

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Should an adolescent patient be allowed confidentiality?

Should adolescents be permitted confidential visits with physicians? Although physicians are more likely than the public to favor confidentiality, the answer hinges upon the adolescent's age, according to an American Medical Association survey published in *American Medical News*.

In separate surveys, 63% of 1,000 physicians and 50% of 1,506 adults said 15-to-17-year-olds should be allowed to consult a physician privately without parents being informed of the nature or outcome of the visit. Thirty percent of the physicians and 45% of the public disagreed.

However, when the question involved adolescents 12 to 14 years of age, 54% of the physicians and 65% of the public said adolescents should not be allowed confidential physician visits. Thirty-nine percent of the physicians and 30% of the public approved of confidential visits.


Despite the split on confidentiality, 69% of the public agreed that their community needs a health clinic that would provide health care services to adolescents for problems such as alcohol and drug abuse, mental health, sexual problems, and birth control. Only 22% disagreed.

Eye care project (continued)

Lawrence, MD, Oklahoma City, president of the Oklahoma State Society of Eye Physicians and Surgeons.

He points out that 34% of Helpline patients had *never* had an eye examination until they called the toll-free number.

By calling the Helpline, US citizens or legal residents 65 years of age or older who do not already have access to an eye physician are eligible to receive services. Volunteer ophthalmologists treat program participants at no out-of-pocket cost, and will accept Medicare assignment or insurance coverage as payment in full (for this project only). For the truly needy with no Medicare coverage, care is offered without charge. Information on eye disease affecting the elderly is sent to all interested callers.

Through the Eye Care Project, ophthalmologists work with local hospitals to make hospital care available at no cost for those who need it. Hospital charges, eyeglasses, and prescription drugs are not paid for through the program. 


When physicians were asked whether they would refer adolescent patients to such community clinics for the previously listed problems, an overwhelming 87% said yes and 8% said no. Neither the physicians nor the public had a clear-cut preference on how these clinics should be financed.

In a related question, the public was nearly unanimous in its opinion on how important it is for the medical profession to address the issue of child abuse. Joining the 93% who said it is very important are an additional 4% who said it is moderately important. Only 1% said it is unimportant.

Seventy-seven percent of the public said it is very important for physicians to address the issue of marketing of alcoholic beverages to minors. Joining the majority were 14% who said it is moderately important. Only 4% each said it "not very important" and "not at all important."

Having the medical profession address the effect of television and movie violence on children is very important to 55% of the adults surveyed. It is moderately important to 28%. Nine percent think it is "not very important." Four percent said it is "not at all important."

The surveyed public was selected using a random sample of all residential telephones in the US. The interviews were conducted between January 29 and February 23, 1987, by Kane, Parsons & Associates of New York.

The surveyed physicians were selected randomly from the AMA's Masterfile of all active physicians in the US. To accurately reflect the nation's physician population, proportionate numbers were AMA members and non-members, male and female physicians, and different ages. The interviews were conducted between January 28 and February 6, 1987, by Tarrance, Hill, Newport and Ryan of Houston. 

**September 1
is the closing date for
the October 1987 Journal**

BOOK SHOP

Clinical Endocrinology and Metabolism: Principles and Practice. (The Science and Practice of Clinical Medicine, Volume 9). By David Rabin and T. Joseph McKenna. New York: Grune and Stratton, 1982. Pp 652, illustrated, price \$69.50.

As Grant Liddle points out in his excellent foreword, there have been few more productive unions than that which has developed during the

present century between basic science and clinical practice in the area of endocrinology. This book attests strongly to this. The material provides a thorough knowledge of the physiology of the endocrine system and the clinical syndromes which have emerged.

This excellent work came about from the clinical and laboratory experience of the two authors at Vanderbilt University School of Medicine. One of the values of this book is its consistency and evenness. It proceeds from biochemical and physiologic elucidation to the clinical problem and its management in well chosen prose. The text is well illustrated with tables, flow sheets, and excellent photographs of patients. Differential diagnosis and treatment are well discussed and the references are carefully chosen.

This may be one of the few textbooks in this field written by only two authors. It is an excellent work and I highly recommend it.

*Harris D. Riley, Jr., MD
Oklahoma City*

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DEATHS

Richard M. Burke, MD 1903 - 1987

OSMA Life Member Richard M. Burke, MD, of Oklahoma City died March 18, 1987. An internist, Dr Burke was born in Langdon, ND, and was graduated from the University of Minnesota Medical School in 1930. He was active in public health and the fight against tuberculosis in Oklahoma, and was an instructor in medicine at the University of Oklahoma.

John Jerome Coyle, MD 1914 - 1987

John J. Coyle, MD, Oklahoma City, a Life Member of the OSMA, died May 21, 1987. Dr Coyle, a native of Kiefer, Okla, was a 1943 graduate of the University of Oklahoma School of Medicine. He established his Oklahoma City practice in obstetrics and gynecology in 1950 after completing two and one half years of active service with the US Army.

IN MEMORIAM

1986

<i>Howard D. Tuttle, MD</i>	<i>August 3</i>
<i>Welborn W. Sanger, MD</i>	<i>September 19</i>
<i>William Carl Ewell, MD</i>	<i>September 20</i>
<i>Marcella Steel, MD</i>	<i>October 1</i>
<i>Terry Dwight Leming, MD</i>	<i>October 13</i>
<i>William Pat Fite, Jr., MD</i>	<i>October 30</i>
<i>Samuel Jackson McDaniel, MD</i>	<i>November 2</i>
<i>Iron Hawthorne Nelson, MD</i>	<i>November 12</i>
<i>John Robert Walter Spencer, MD</i>	<i>December 4</i>

1987

<i>Charles Sylvanus Maben, MD</i>	<i>February 13</i>
<i>Edward Leon Moore, MD</i>	<i>February 14</i>
<i>Ralph Cameron Emmott, MD</i>	<i>February 16</i>
<i>James Laurel Haddock, Jr., MD</i>	<i>February 19</i>
<i>Donald J. Blair</i>	<i>March 16</i>
<i>Richard M. Burke, MD</i>	<i>March 18</i>
<i>Eldon Clyde Mohler, MD</i>	<i>March 21</i>
<i>Paul Lewis Nave, MD</i>	<i>March 26</i>
<i>George Michael Willkom III, MD</i>	<i>March 30</i>
<i>Odis A. Cook, MD</i>	<i>April 4</i>
<i>Lawrence Edward Silvey, MD</i>	<i>April 9</i>
<i>Victor Gary Anderson, MD</i>	<i>April 10</i>
<i>Edgar W. Young, Jr., MD</i>	<i>April 12</i>
<i>Paul Newman Atkins, Jr., MD</i>	<i>April 20</i>
<i>John Wesley Williams, MD</i>	<i>May 16</i>
<i>John Jerome Coyle, MD</i>	<i>May 21</i>
<i>Scott Allen Morris, MD</i>	<i>May 24</i>
<i>Gladys Christine Smith, MD</i>	<i>May 27</i>
<i>John Ronald Watson, MD</i>	<i>June 14</i>
<i>Thomas Arthur Hosty, MD</i>	<i>June 17</i>

Thomas Arthur Hosty, MD 1941 - 1987

Oklahoma City pathologist Thomas A. Hosty, MD, died June 17, 1987, following a brief illness. A 1966 graduate of the University of Alabama School of Medicine, Dr Hosty held positions with the University of Wisconsin and Washington University, St Louis, before moving to Oklahoma City in 1975. In addition to his medical practice, he was a faculty member at the University of Oklahoma College of Medicine and at Rose State College.

Charles Sylvanus Maben, MD 1901 - 1987

Retired general practitioner Charles S. Maben, MD, of Okmulgee died February 13, 1987. Dr Maben, a 1933 graduate of the University of Arkansas School of Medicine, was a Life Member of the OSMA.

Dwight D. Pierson, MD 1905 - 1986

Dwight D. Pierson, MD, an OSMA Life Member, died July 28, 1986. Dr Pierson was a general practitioner in Mangum. He was graduated from the University of Oklahoma School of Medicine in 1932 and interned at Oklahoma City's University Hospital. He practiced briefly in Buffalo, Okla, before beginning four years' active duty with the US Army Medical Corps.

(continued)

Deaths (continued)

Lawrence Edward Silvey, MD **1931 - 1987**

Family practitioner Lawrence E. Silvey, MD, of Bethany died April 9, 1987. Dr Silvey was born in Seymour, Mo, and graduated from the University of Kansas School of Medicine in 1957. He served his internship at Orange County General Hospital, Orange, Calif, before moving to Oklahoma.

Gladys Christine Smith, MD **1912 - 1987**

Retired radiologist Gladys C. Smith, MD, Vinita, died May 27, 1987. Dr Smith, an OSMA Life Member, was born in Byron, Okla. A 1947 graduate of the University of Oklahoma School of Medicine, she interned in Washington, DC, and returned to Oklahoma City for her residency training.

John Ronald Watson, MD **1942 - 1987**

Oklahoma City internist John R. Watson, MD, died June 14, 1987. The Boley native was a 1971 graduate of the University of Oklahoma College of Medicine. He completed his internship and residency training at Harlem Hospital in New York City and from 1974 to 1977 was a clinical instructor in medicine at Columbia University. He returned to Oklahoma City in 1977 to establish a private practice in internal medicine.

John Wesley Williams, MD **1923 - 1987**

OSMA Life Member John W. Williams, MD, Enid, died May 16, 1987. An obstetrician-gynecologist, Dr Williams was born in Anderson, SC, and was graduated from Vanderbilt University School of Medicine, Nashville, in 1947. After completing his residency training, he moved to Oklahoma and established a private practice in Enid in 1953.

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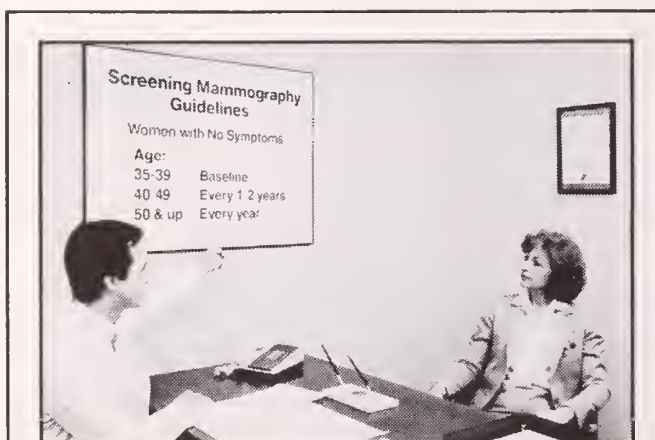
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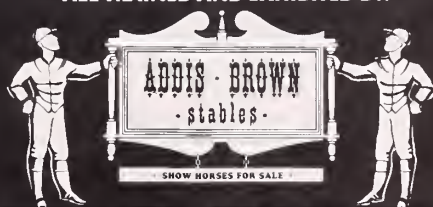


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Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other anti-hypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth, anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions, nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances, postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

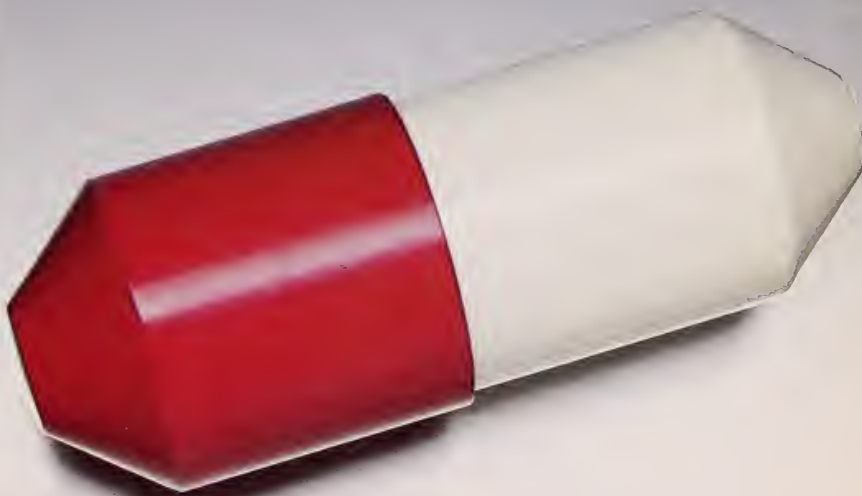
Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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Potassium-Sparing

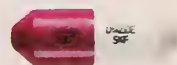
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Percent of patients ulcer-free after 1 year of therapy

ZANTAC
150 mg h.s. (n=60)

84%*

cimetidine
400 mg h.s. (n=66)

57%

ZANTAC
150 mg h.s. (n=243)

77%†

cimetidine
400 mg h.s. (n=241)

63%

All patients were permitted prn antacids for relief of pain.
Adopted from Silvis¹ and Gough²

These two trials^{1,2} used the currently recommended dosing regimen of cimetidine (400 mg h.s.) and ranitidine (150 mg h.s.). A comparison of other dosing regimens has not been studied. The studied dosing regimens are not equivalent with respect to the degree and duration of acid suppression or suppression of nocturnal acid.

The superiority of ranitidine over cimetidine in these trials indicates that the dosing regimen currently recommended for cimetidine is less likely to be as successful in maintenance therapy.

*P=0.01 †P=0.0004 % life-table estimates

Zantac[®] 150 h.s.
ranitidine HCl/Glaxo 150 mg tablets

Glaxo / **ROCHE** See next page for references and Brief Summary of Product Information.

ZAN375 July 1987

References: 1. Silvis SE, Griffin J, Hardin R, et al: Final report on the United States multicenter trial comparing ranitidine to cimetidine as maintenance therapy following healing of duodenal ulcer. *J Clin Gastroenterol* 1985;7(6):482-487.
2. Gough KR, Karman MG, Bardhan KD, et al: Ranitidine and cimetidine in prevention of duodenal ulcer relapse: A double-blind, randomised, multicentre, comparative trial. *Lancet* 1984;ii:659-662.

ZANTAC® 150 Tablets
(ranitidine hydrochloride)
ZANTAC® 300 Tablets
(ranitidine hydrochloride)

**BRIEF SUMMARY OF
PRODUCT INFORMATION**

The following is a brief summary only. Before prescribing, see complete prescribing information in ZANTAC® product labeling.

INDICATIONS AND USAGE: ZANTAC® is indicated in:

1. Short-term treatment of **active duodenal ulcer**. Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer**. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD)**. Symptomatic relief commonly occurs within one or two weeks after starting therapy and is maintained throughout a six-week course of therapy.

In active duodenal ulcer, active, benign gastric ulcer, hypersecretory states, and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: ZANTAC® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: Symptomatic response to ZANTAC® therapy does not preclude the presence of gastric malignancy.

Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see **DOSAGE AND ADMINISTRATION**). Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

False-positive tests for urine protein with Multistix® may occur during ZANTAC therapy, and therefore testing with sulfasalicylic acid is recommended.

Although recommended doses of ZANTAC do not inhibit the action of cytochrome P-450 enzymes in the liver, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Lack of experience to date precludes recommending ZANTAC for use in children or pregnant patients. Since ZANTAC is secreted in human milk, caution should be exercised when administered to a nursing mother.

ADVERSE REACTIONS: Headache, sometimes severe, seems to be related to ZANTAC® administration. Constipation, diarrhea, nausea/vomiting, and abdominal discomfort/pain have been reported. There have been rare reports of malaise, dizziness, somnolence, insomnia, vertigo, tachycardia, bradycardia, premature ventricular beats, and arthralgias. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

There have been rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

Although controlled studies have shown no antiandrogenic activity, occasional cases of gynecmastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

Incidents of rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia, have been reported, as well as rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg twice daily. An alternate dosage of 300 mg once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison Syndrome): The current recommended adult oral dosage is 150 mg twice a day. In some patients it may be necessary to administer ZANTAC 150-mg doses more frequently. Doses should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/day have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg twice a day.

GERD: The current recommended adult oral dosage is 150 mg twice a day.

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with ZANTAC, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: ZANTAC® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) and unit dose packs of 100 tablets (NDC 0173-0393-47).

ZANTAC® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 tablets (NDC 0173-0344-42) and unit dose packs of 100 tablets (NDC 0173-0344-47).

Store between 15° and 30° C (59° and 86° F) in a dry place. Protect from light. Replace cap securely after each opening.

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October 1986

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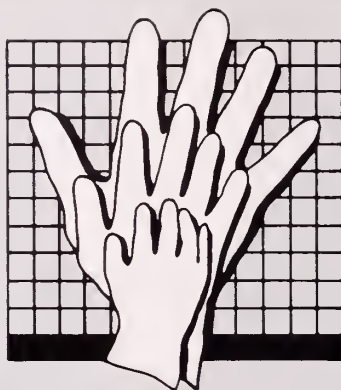
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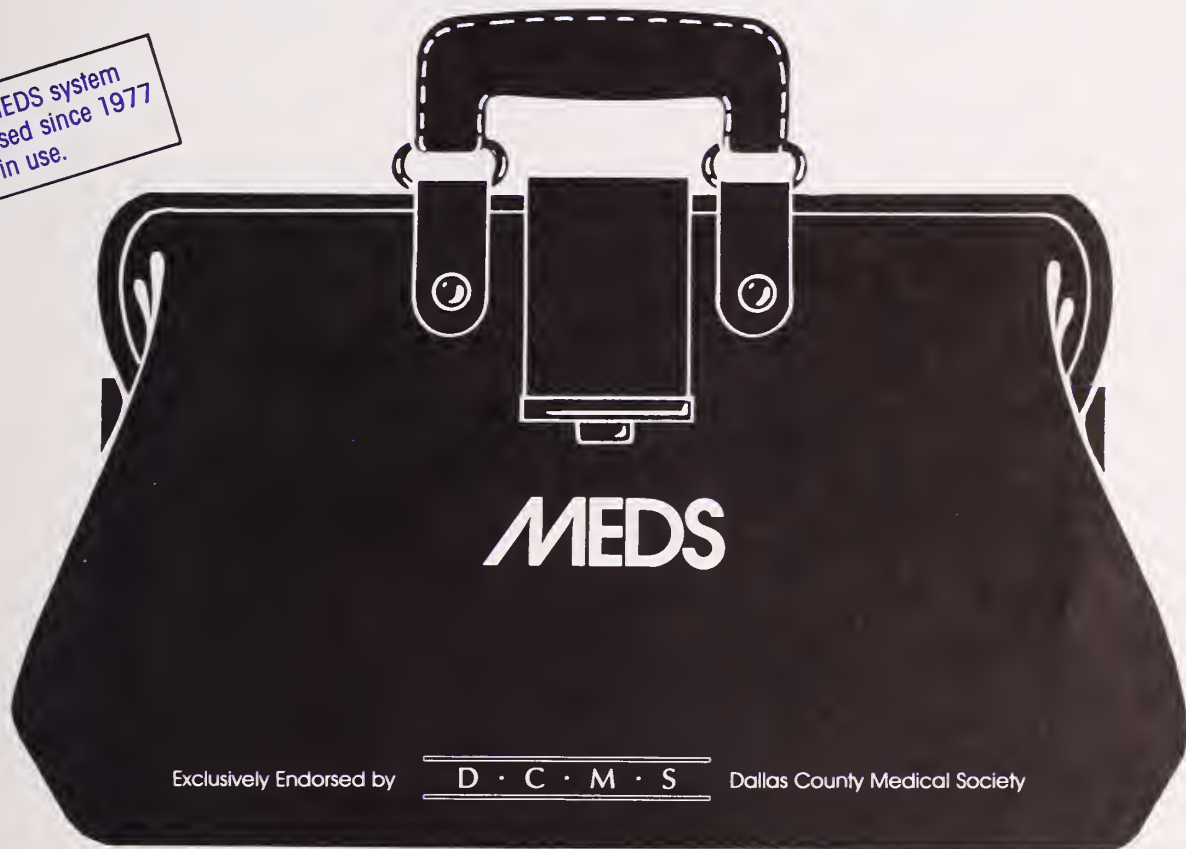
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■ **The Oklahoma Physicians Fifteenth Annual Winter Seminar** will begin Saturday, December 26 in Copper Mountain, Colo. The seven-day meeting will conclude January 2. Featured will be presentations from the faculty of the University of Oklahoma College of Medicine and the registrants themselves. Physicians registering now will be able to participate in program development, and those signing up before August 31 will earn a \$60 discount on their registration fee. For details contact **Irwin H. Brown, MD**, 3435 NW 56th, #206, Oklahoma City, OK 73112, (405) 946-0548.

■ **The Oklahoma Society of Clinical Oncology** is now accepting membership applications from interested physicians. The society was established for the purpose of promoting the exchange and distribution of information relating to the diagnosis and treatment of neoplastic diseases as well as the resulting economic problems. Membership is open to all physicians who are board-eligible in oncology or who have had at least two years of oncologic experience beyond residency training. Dues are \$25 a year. To receive an application, contact **Kay Bickham**, 601 Northwest Expressway, Oklahoma City, OK 73118.

■ **Roger D. Quinn, MD, Oklahoma City**, is the recipient of the Oklahoma City Clinic's Blesh-Rucks Award for 1986. The award is presented each year to the clinic physician who, in the judgment of his clinic peers, best exemplifies clinical excellence. Dr Quinn, an obstetrician-gynecologist, joined the clinic in 1971. He is the nineteenth physician to receive the award since its establishment in 1965.

■ **Three Tulsa internists recently affiliated** their medical practice, South Tulsa Diagnostic Physicians, with the Springer Clinic. Effective July 1, the practice of **Richard N. Marple, MD**, **Christopher V. Teter, MD**, and **Edward L. Taylor IV, MD**, became known as Springer Diagnostic Physicians. The physicians stayed at their former address, bringing to seven the number of Springer Clinic locations in the Tulsa area.

■ **Numerous studies indicate that lumpectomy** plus radiation therapy produces the same survival rate as modified radical mastectomy in patients with early breast cancer, and suggest local recurrence rates may be lower in patients who undergo radiation. Now, a study in the *Archives of Surgery*

concludes that immediately implanting a tiny radioactive source at the tumor site after lumpectomy may reduce local failure rates even further. **William R. Jewell, MD**, of the University of Kansas Medical Center, Kansas City, and colleagues, used the technique to treat 110 breast cancers in 107 patients over a period of more than four years. The women underwent simple tumor excision, immediate implantation with iridium 192, and complete axillary node dissection followed by external beam radiation therapy. There were two recurrences over the follow-up period, the study says. "These preliminary data suggest that local treatment failure can be minimized by aggressive, immediate intraoperative implantation of the tumor bed with iridium Ir 192," it concludes.

■ **Application forms for research awards** by the American Heart Association, Oklahoma Affiliate, are now available in the affiliate office in the Cameron Building, 2915 North Classen, Suite 220, Oklahoma City. Awards will include research grants in aid, fellowships, and Young Investigator awards. Deadline for submission is November 1, 1987.

■ **Jean D. Pitts, MD, Oklahoma City** cardiologist, has received a first place award for her quarterly newsletter *Heartline*. The award was presented by the Oklahoma City Chapter of the Public Relations Society of America.

■ **Tulsa cardiologist Robert D. Okada, MD**, was the author of two manuscripts published in February. "Early Differentiation of Viable and Nonviable Myocardium After Reperfusion Using Serial Thallium Imaging" appeared in the *American Heart Journal*, and the *American Journal of Cardiology* published "Independent Adverse Effects of Mild Hypertension on Left Ventricular Systolic Function During Exercise."

■ **The OU Tulsa Medical College Class of 1987** recently announced the winners of its Aesculapian awards. **Jose R. Medina, MD**, a cardiologist, received the part-time faculty member award, and the full-time faculty member award was given to internist **Dala R. Jarolim, MD**.

■ **David L. Harper, MD, Tulsa urologist**, was the winner of the Physicians Tennis Tournament in Tulsa recently. **Gary Singh, MD**, was the runner-up.



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Almost equal diuretic response occurs after oral and parenteral administration of Bumex. If impaired gastrointestinal absorption is suspected or oral administration is not practical, Bumex should be given by the intramuscular or intravenous route.

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CONTRAINDICATIONS: Anuria. Hypersensitivity and in patients in hepatic coma or in states of severe electrolyte depletion. Although Bumex can be used to induce diuresis in renal insufficiency, any marked increase in blood urea nitrogen or creatinine, or the development of oliguria during therapy of patients with progressive renal disease, is an indication for discontinuation of treatment.

WARNINGS: Dose should be adjusted to patient's needs. Excessive doses or too frequent administration can lead to profound water loss, electrolyte depletion, dehydration, reduction in blood volume and circulatory collapse with the possibility of vascular thrombosis and embolism, particularly in elderly patients.

Prevention of hypokalemia requires particular attention in patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis and ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, certain diarrheal states, or other states where hypokalemia is thought to represent particular added risk to the patients.

In patients with hepatic cirrhosis and ascites, sudden alterations of electrolyte balance may precipitate hepatic encephalopathy and coma. Treatment in such patients is best initiated in the hospital with small doses and careful monitoring of the patient's clinical status and electrolyte balance. Supplemental potassium and/or spironolactone may prevent hypokalemia and metabolic alkalosis in these patients. In cats, dogs and guinea pigs, Bumex has been shown to produce ataxicity. Since Bumex is about 40 to 60 times as potent as furosemide, it is anticipated that blood levels necessary to produce ataxicity will rarely be achieved. The potential for ototoxicity increases with intravenous therapy, especially at high doses.

Patients allergic to sulfonamides may show hypersensitivity to Bumex.

PRECAUTIONS: Measure serum potassium periodically and add potassium supplements or potassium-sparing diuretics, if necessary. Periodic determinations of other electrolytes are advised in patients treated with high doses or for prolonged periods, particularly in those on low salt diets.

Hyperurcemia may occur. Reversible elevations of the BUN and creatinine may occur, especially with dehydration and in patients with renal insufficiency. Bumex may increase urinary calcium excretion. Possibility of effect on glucose metabolism exists. Periodic determinations of blood sugar should be done, particularly in patients with diabetes or suspected latent diabetes. Patients should be observed regularly for possible occurrence of blood dyscrasias, liver damage or idiosyncratic reactions.

Especially in presence of impaired renal function, use of parenterally administered Bumex should be avoided in patients to whom aminoglycoside antibiotics are also being given, except in life-threatening conditions.

Drugs with nephrotoxic potential and bumetanide should not be administered simultaneously. Since lithium reduces renal clearance and adds a high risk of lithium toxicity, it should not be given with diuretics.

Probenecid should not be administered concurrently with Bumex.

Concurrent therapy with indomethacin not recommended.

Bumex may potentiate the effects of antihypertensive drugs, necessitating reduction in dosage.

Interaction studies in humans have shown no effect on digoxin blood levels.

Interaction studies in humans have shown Bumex to have no effect on warfarin metabolism or on plasma prothrombin activity.

Pregnancy: Bumex should be given to a pregnant woman only if the potential benefit justifies the potential risk to the fetus.

Bumetanide may be excreted in breast milk.

Pediatric Use: Safety and effectiveness below age 18 not established.

ADVERSE REACTIONS: Muscle cramps, dizziness, hypotension, headache and nausea, and encephalopathy (in patients with preexisting liver disease).

Less frequent clinical adverse reactions are weakness, impaired hearing, rash, pruritus, hives, electrocardiogram changes, abdominal pain, arthritic pain, musculoskeletal pain and vomiting. Other clinical adverse reactions are vertigo, chest pain, ear discomfort, fatigue, dehydration, sweating, hyperventilation, dry mouth, upset stomach, renal failure, asterixis, itching, nipple tenderness, diarrhea, premature ejaculation and difficulty maintaining an erection.

Laboratory abnormalities reported are hyperurcemia, azotemia, hyperglycemia, increased serum creatinine, hypochloremia, hypokalemia, hyponatremia, and variations in CO₂ content, bicarbonate, phosphorus and calcium. Although manifestations of the pharmacologic action of Bumex, these conditions may become more pronounced by intensive therapy. Diuresis induced by Bumex may also rarely be accompanied by changes in LDH, total serum bilirubin, serum proteins, SGOT, SGPT, alkaline phosphatase, cholesterol, creatinine clearance, deviations in hemoglobin, prothrombin time, hematocrit, platelet counts and differential counts. Increases in urinary glucose and urinary protein have also been seen.

DOSAGE AND ADMINISTRATION:

Oral Administration: The usual total daily dosage is 0.5 to 2.0 mg and in most patients is given as a single dose.

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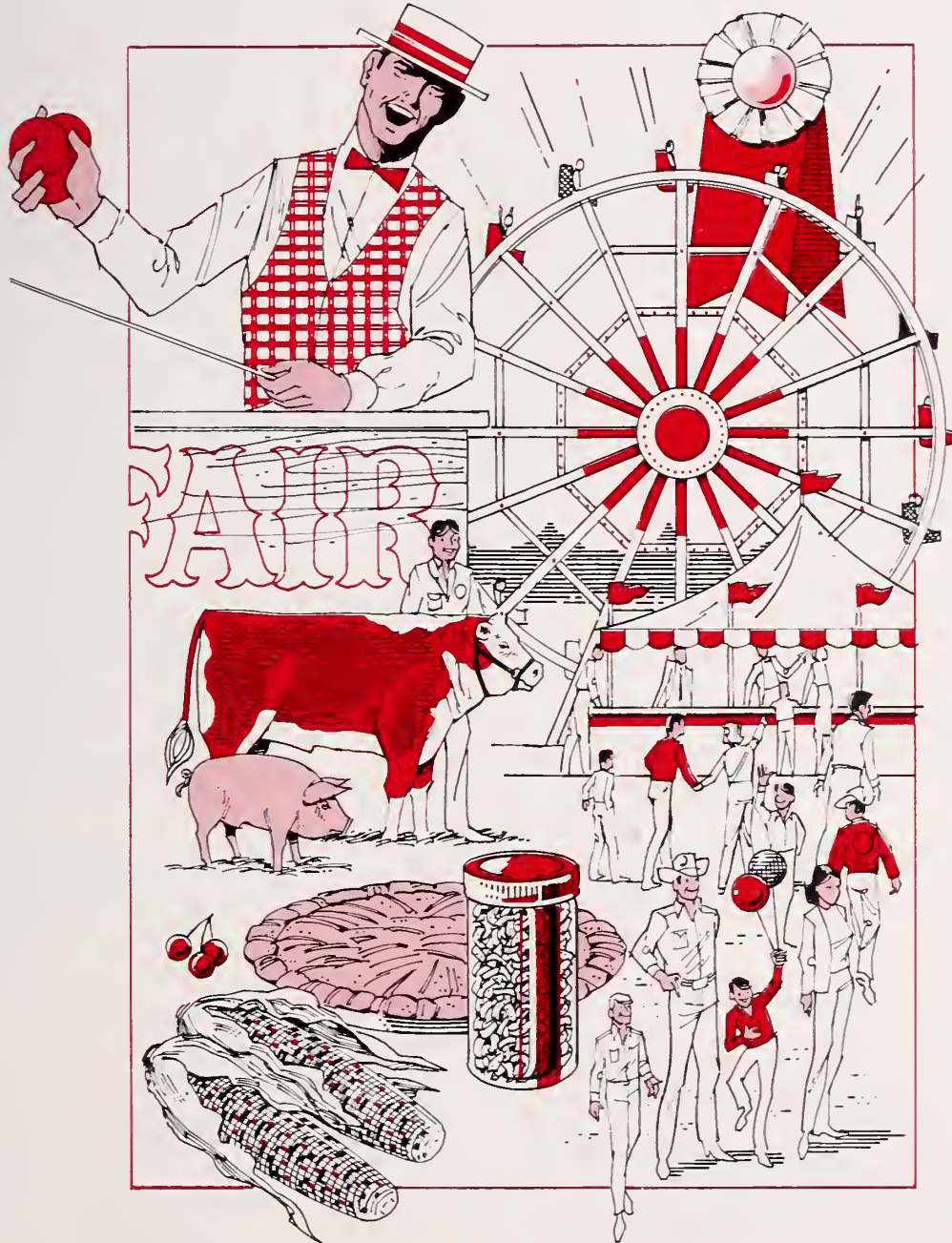
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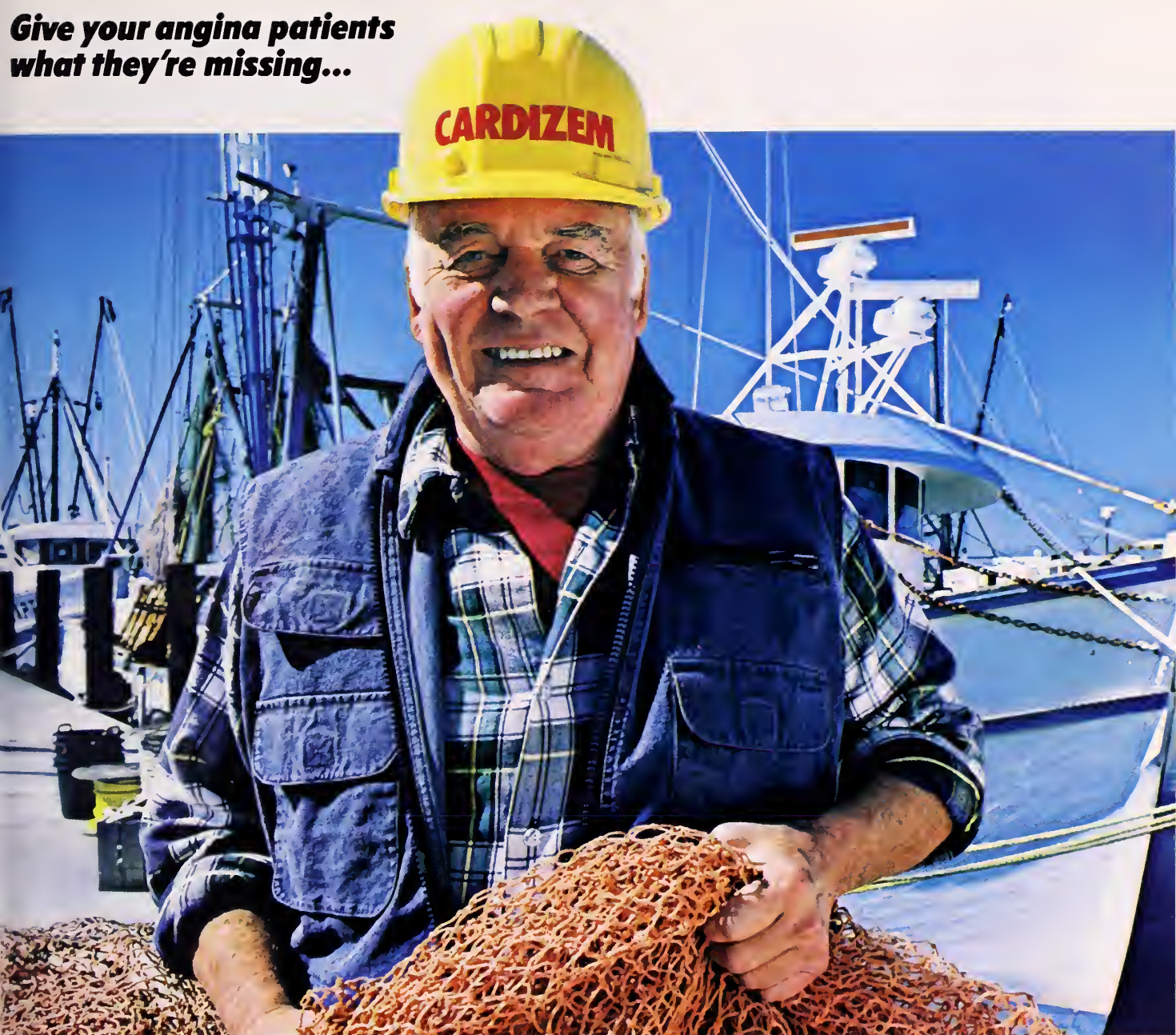
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CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

- 1. Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
- 2. Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
- 3. Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
- 4. Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic

function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in *in vitro* bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but if should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably asso-

ciated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), osteoarthritis (1.2%). In addition, the following events were reported infrequently (less than 1%):

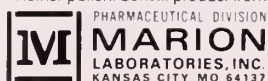
Cardiovascular:	Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.
Nervous System:	Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.
Gastrointestinal:	Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.
Dermatologic:	Petechiae, pruritus, photosensitivity, urticaria.
Other:	Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarthralgia, pain, polyuria, sexual difficulties.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. Issued 9/86

See complete Professional Use Information before prescribing

References: 1. Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers. Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. *Am Heart J* 1983; 106(6):1341-1347. 2. Shopiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. *Consultant* 1984; 24(Dec): 150-159. 3. Johnston DL, Lesoway R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. *Am J Cardiol* 1985; 55:680-687. 4. Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): *Heart Disease: A Textbook of Cardiovascular Medicine*, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. 5. Schroeder JS: Calcium and beta blockers in ischemic heart disease. When to use which. *Mod Med* 1982; 50(Sept):94-116.

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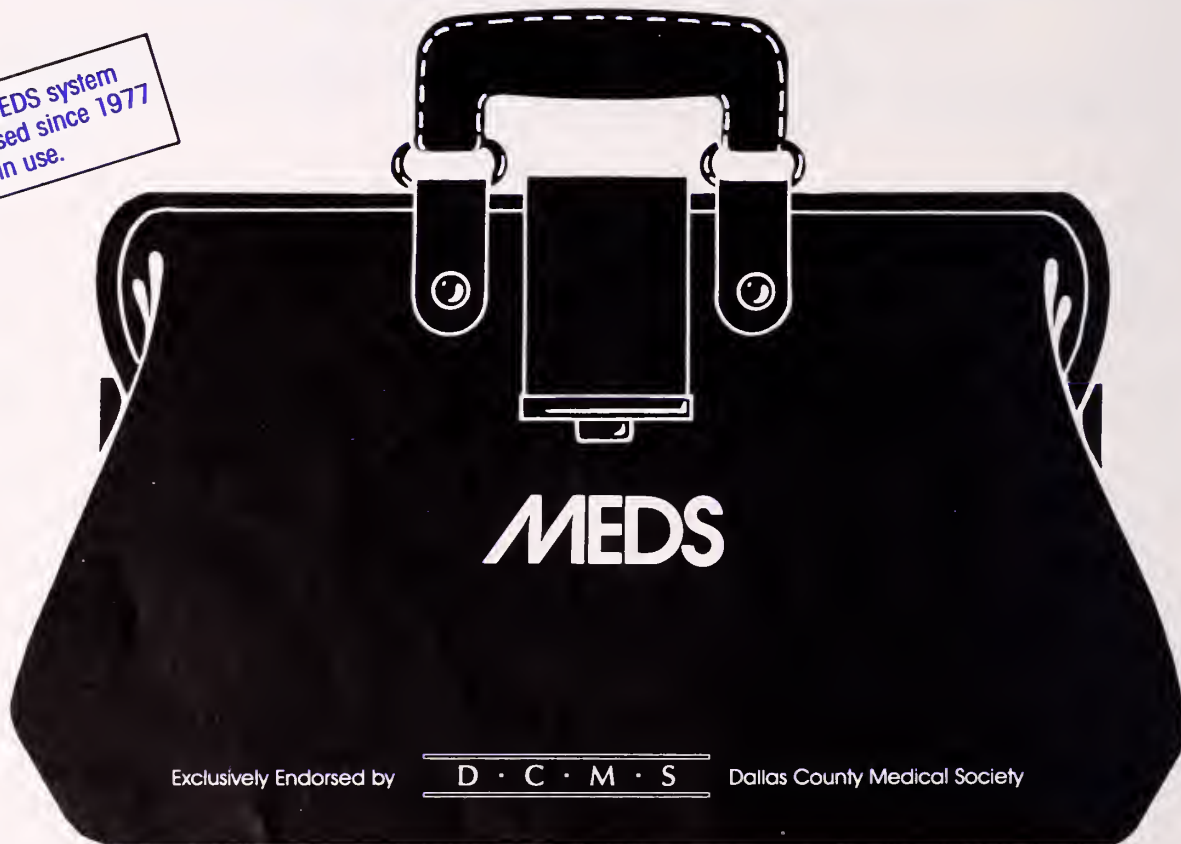
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BRIEF SUMMARY

CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate.

PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that the simultaneous administration of CARAFATE with tetracycline, phenytoin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. The clinical significance of these animal studies is yet to be defined.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No evidence of drug-related tumorigenicity was found in chronic oral toxicity studies of 24 months' duration conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies have not been conducted.

Pregnancy: Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED

CARAFATE (sucralfate) 1-gm pink tablets are supplied in bottles of 100 and in Unit Dose Identification Paks of 100. The tablets are embossed with MARION/1712. Issued 3/84

References:

1. Korman MG, Shaw RG, Hansky J, et al: *Gastroenterology* 80:1451-1453, 1981.
2. Korman MG, Hansky J, Merrett AC, et al: *Dig Dis Sci* 27:712-715, 1982.
3. Brandstaetter G, Kratochvil P: *Am J Med* 79(suppl 2C):36-38, 1985.
4. Marks IN, Wright JP, Gilinsky NH, et al: *J Clin Gastroenterol* 8:419-423, 1986.
5. Lam SK, Hui WM, Lau WY, et al: *Gastroenterology* 92:1193-1201, 1987.

Another patient benefit product from



1594H7

Ulcer therapy that won't yield, even to smoking

YIELD



What do you do for duodenal ulcer patients who should stop smoking, but won't? Both cimetidine¹ and ranitidine² have been shown less effective in smokers than nonsmokers.

Choose CARAFATE® (sucralfate/Marion). Two recent studies show Carafate to be as effective in smokers as nonsmokers.^{3,4} A difference further illustrated in a 283-patient study comparing sucralfate to cimetidine⁵:

Ulcer healing rates:
(at four weeks of therapy)⁵

Sucralfate:

All patients	79.4%
Smokers	81.6%*

Cimetidine:

All patients	76.3%
Smokers	62.5%

*Significantly greater than cimetidine smoker group ($P < .05$).

Carafate has a unique, nonsystemic mode of action that enhances the body's own ulcer healing ability and protects the damaged mucosa from further injury.

When your ulcer patient is a smoker, prescribe the ulcer medication that won't go up in smoke: safe, nonsystemic Carafate.

Nothing works like


CARAFATE®
sucralfate/Marion

Please see adjoining page for references and brief summary of prescribing information.

1594H7

There's never been a better time for her.





and PREMARIN[®]

**Proven benefits beyond relief
of vasomotor symptoms**

**No other estrogen proven
effective for osteoporosis**

Only conjugated estrogens tablets have established efficacy in both osteoporosis¹ and vasomotor symptoms* at 0.625 mg/day. No other estrogen, oral or transdermal, has established clinical evidence or minimum effective dose in both indications.

No estrogen proven safer

PREMARIN is the most extensively tested estrogen, with an unsurpassed record of long-term safety.

And clinical evidence shows a significantly reduced risk of endometrial hyperplasia when cycled with a progestin.²

PREMARIN[®]
(conjugated estrogens tablets)

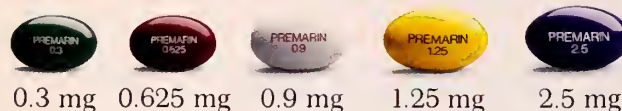
Most trusted for more reasons

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary
of prescribing information.

For moderate-to-severe vasomotor symptoms and for osteoporosis

PREMARIN® (conjugated estrogens tablets)



The appearance of these tablets is a trademark of Ayerst Laboratories.

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream, in a nonliquefying base

1 ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA

Three independent, case-controlled studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case-controlled studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semi-annual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration, it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equi-estrogenic doses.

2 ESTROGENS SHOULD NOT BE USED DURING PREGNANCY

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing, in later life, a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case-controlled study estimated a 4.7-fold increased risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17 α -dihydroequilin, together with smaller amounts of 17 α -estradiol, equilin, and 17 α -dihydroequilin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe vasomotor symptoms associated with the menopause (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) Osteoporosis (abnormally low bone mass). Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae.

PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (see Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Estrogens have been reported to increase the risk of endometrial carcinoma (see Boxed Warning). However, a recent large, case-controlled study indicated no increase in risk of breast cancer in postmenopausal women. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgical thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism, and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

For atrophic vaginitis

PREMARIN® (conjugated estrogens)

Vaginal Cream

0.625 mg/g



Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention, such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Pre-existing uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not yet complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

- a. Increased sulfobromophthalene retention
- b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability
- c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T_4 by column, or T_4 by radioimmunoassay. Free T_3 resin uptake is decreased, reflecting the elevated TBG; free T_4 concentration is unaltered
- d. Impaired glucose tolerance
- e. Decreased pregnandiol excretion
- f. Reduced response to metyrapone test
- g. Reduced serum folate concentration
- h. Increased serum triglyceride and phospholipid concentration

As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

Long-term, continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. However, in a recent, large case-controlled study of postmenopausal women there was no increase in risk of breast cancer with use of conjugated estrogens.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow, dysmenorrhea, premenstrual-like syndrome, amenorrhea during and after treatment, increase in size of uterine fibromyoma, vaginal candidiasis, change in cervical erosion and in degree of cervical secretion, cystitis-like syndrome, tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating, cholestatic jaundice, chloasma or melasma which may persist when drug is discontinued, erythema multiforme, erythema nodosum, hemorrhagic eruption, loss of scalp hair, hirsutism, steepening of corneal curvature; intolerance to contact lenses, headache, migraine, dizziness, mental depression, chorea, increase or decrease in weight; reduced carbohydrate tolerance, aggravation of porphyria, edema, changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate-to-severe vasomotor symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 mg to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically.* Osteoporosis: Female castration. Osteoporosis — 0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off). Female castration — 1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three- to six-month intervals.

Usual dosage range: 2 g to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

1. Lindsay R, Hart OM, Clark OM. The minimum effective dose of estrogen for prevention of postmenopausal bone loss. *Obstet Gynecol* 1984;63:759-763.
2. Studd JWW, Thom MH, Paterson MEL, et al. The prevention and treatment of endometrial pathology in postmenopausal women receiving exogenous estrogens, in Pasetto N, Paoletti R, Ambrosi JL (eds). *The Menopause and Postmenopause*. Lancaster, England, MTP Press Ltd, 1980, chap 13.

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OSMA
FALL "THANKSGIVING" TOUR

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November 22 - 29

Visit one of the world's most exciting cities with the Oklahoma State Medical Association London Tour. You'll be staying in the London International Hotel, just a few blocks away from Harrod's, London's world famous shopping center.

Optional side tour is available to Windsor Castle, Salisbury and Stonehenge, Canterbury and the beloved country home of Sir Winston Churchill, Charwell. And don't forget a visit to the Tower of London to view the Crown Jewels!

**(Optional)
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Tuesday: Professional Liability (Malpractice) in England
A discussion of the professional liability situation in England led by one of London's most knowledgeable attorneys on the subject.

Wednesday: A Visit to Lloyd's of London
Insurance companies, just like individuals, buy insurance to protect themselves. The international center for "reinsurance" is Lloyd's of London. A representative from one of the brokerage firms will explain international reinsurance.

Thursday: Tort Reform and the English Approach
A discussion of and comparison between the U.S. and English court system regarding professional liability lawsuits. Could the English approach reduce suits in the U.S.?

Friday: Courtrooms Are for Lawyers
A presentation about the entire conduct of a professional liability lawsuit beginning with the actual incident and ending with an appeal to the State Supreme Court.

Seminar Fee: \$150 per person

Includes certificate of attendance and the appropriate **tax deduction information.**

For reservations contact:
Debbie Hinson
Oklahoma State Medical Association
(405) 843-9571
or call toll free in Oklahoma
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**\$998.00 per person
(double occupancy)**

Items Included:

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- Welcome cocktail party
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This number could save your life.

You might not be aware that some types of cancer are preventable, or that many cancers are controllable, and some are even curable. Through early detection and prompt treatment you could help save your life.

Those are the facts, but only you can do something about them.

For information on prevention and detection or answers to specific questions you may have about cancer, call the Cancer Information Service, free:

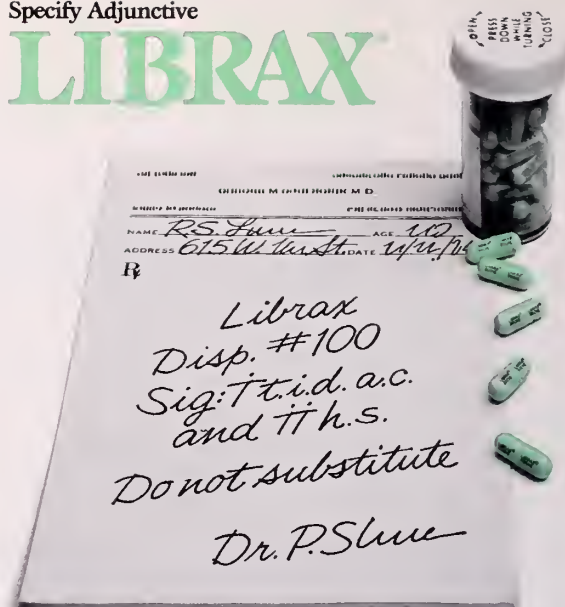
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Prevention. Early Detection.
Prompt Treatment.

*This message is donated as a public service by this publication.
National Cancer Institute, OCIS, OCIT*

Specify Adjunctive

LIBRAX



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide

Please consult complete prescribing information, a summary of which follows:

- * **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur. **Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



Roche Products Inc.
Manati, Puerto Rico 00701

P. 0186

To insist
on the brand,
"Do Not Substitute"
on your prescription.

When brain and bowel conflict...



It's time for the Peacemaker.

In irritable bowel syndrome* anxiety can aggravate intestinal symptoms, which may further intensify anxiety — a distressing cycle of brain/bowel conflict. Librax intervenes with two well-known compounds. The Librium® (chlordiazepoxide HCl/Roche) component safely relieves anxiety. And Quarzan® (clidinium bromide/Roche) provides antisecretory and antispasmodic action to relieve discomfort associated with intestinal hypermotility.

Dual action — for peace between brain and bowel. Because of possible CNS effects, caution patients about engaging in activities requiring complete mental alertness. Specify Adjunctive

LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl
and 2.5 mg clidinium bromide

*Librax has been evaluated as possibly effective as adjunctive therapy in the treatment of peptic ulcer and the irritable bowel syndrome.

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If you're being held captive in a jail built of paper work and personnel problems, you need rescued by the professionals. Professional Office Management is the logical answer for doctors who want to spend their time examining patients, not ledger books.

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Volunteer Work

You may not realize it, but you are paying part of the overhead expenses of a number of insurance companies. They want you to believe that the things you do for their bottom line are simply a part of your obligations to your patients.

If you believe this broadly promoted deception, you are supporting a charity the magnitude of which you do not appreciate.

Beyond the very significant expenses of clerical services and postage; beyond the costs of submitting detailed reports, diagnoses, justifications, clarifications, and case summaries; beyond the tolls for long distance telephone calls and their documentation; beyond all of these costly contributions you make to the companies that sell medical, health, and hospital insurance policies, you are also contributing a portion of your customary fee and, frequently, two or three months of interest earned by your money but paid to the insurance companies.

Certainly we have an obligation to conserve our patients' financial resources; to provide the best possible care for the lowest possible cost. However, we have and should assume no obligations to our patients' insurance companies. We should recognize such mercenary entities as what they are: adversaries to whatever costs money.

Recognizing that we physicians directly influence the cost of their product, the insurance companies attempt to control us and the cost of our product, medical care. They tell their customers what the company will pay for, lumping it under the generic title "high quality health care." The companies then set about telling their "beneficiaries," — our patients — what *we* must do in order to validate the provisions of *their* insurance policies. Of course, the patients are convinced that we are obligated to do everything the insurance company tells us to do, that if their insurance company doesn't pay for it, they don't need

it and, finally, that their insurance company knows what is best for its customers and will pay for it.

These delusions are the health insurance industry's stock in trade and we, the physicians of this nation, are promoting the delusions. We are working for our adversaries, the lowest bidders for our services.

If you doubt that you are an unpaid employee of health insurance companies, stop and think. Ask yourself a few questions:

Do you attempt to interpret the provisions of health insurance policies to your patients?

Do you get "approval" from an insurance company before hospitalizing a patient?

Do you ever modify your management of a patient's illness because of the provisions of his insurance policy?

Do you base your fees on a schedule of allowances adopted by an insurance company?

Do you ever tell a patient that his insurance policy does not pay for good medical care and will not influence your recommendations for therapy?

Do you collect a fee for any of the reports you submit to your patients' insurance companies?

Do you ever explain to a patient that his insurance company wants to provide the cheapest, not the best, medical care?

With fewer patients being admitted to hospitals and for shorter periods of time, with many hospitals taking or facing bankruptcy, with the purchasing power of physicians' incomes declining and the costs of "health care" still rising, did you ever ask yourself or your patients where the money was going?

So how do you like being a volunteer for the insurance industry?

Can you afford any other charities?

—MRJ

If I'd knowed then what I knew now I'd never have did what I done?!

It is interesting to look back on recent medical-economic history.

What would have happened if, in 1965, the physicians of this country had said that Medicare (in the form in which it was passed) was not in the best interests of our patients, and therefore "we will not participate."



It is true that, overall, the Medicare program has resulted in more and better (paid for) care than before — but at enormous costs — bewildering even to the most liberal socialistic politician. The politicians never did (and do not to this day) understand the calling of the dedicated physician, who did not let people who were in need go without needed medical care. They did not understand that the cost figures they based their calculations upon did not include the free care that had been rendered without cost to the medically needy for many years — since time immemorial.

Suddenly, they say, "Hey — where's all this money going?" We told them where it would be going!!!

But they did not listen . . . Will they not listen now???

It would seem that we have the same political persuasion in Congress today that we had in 1964 when the Medicare law was passed.

There has been a reasonable — and cost effective — alternative presented by your American Medical Association. It avoids most, if not all, of the pitfalls of the present system and would put the Medicare system on a firm financial basis (if the politicians don't pass a "Mother-in-Law" clause, ie, special

interest provisions not included in the original legislation).

But what is happening in Washington is tantamount to prostitution.

The politicians have taken a needed proposal for a program and begun to load it down with "Mother-in-Law" clauses that the working class of the country cannot afford (AND SHOULD NOT AFFORD).

They have not learned from history — and "those who do not learn from history are destined to make the same mistakes." I wish it were that simple.

I do not believe most of them did not learn. I believe they prostitute themselves for votes.

Ask the average Medicare recipient (not the welfare recipient, nor the affluent).

I believe they will tell you they spend more out of their pocket for medical care now than they did prior to Medicare.

If we do not form an alliance with our patients to combat this political prostitution,

Then our cause (a noble cause) is lost.

The concept that has produced the most modern of medical care . . .

The concept that has produced the medical care that is the envy of the world . . .

WILL BE LOST!!!

Talk to your patients, be kind to them, continue to take good care of them. Write, talk to your congressmen, teach them history . . .

and convince them . . .

WE WILL NOT BE A PARTY
TO POLITICAL PROSTITUTION.

J. Lee Thompson, M.D.

Impact of Education on Cephalosporin Prescribing Patterns

CARLA B. FRYE, PHARM.D; BARBARA BAKER, RN; DANIEL J. SEXTON, MD; F. KELLY DOUGHERTY

Extensive educational efforts and control measures can be very effective in altering physicians' use of cephalosporins and in controlling hospital expenditures for these antibiotics.

New cephalosporins have proliferated at an astounding rate. This flood of new agents has caused considerable confusion among practicing physicians. For many doctors it is difficult not only to select the optimal cephalosporin but to remember the proper dosage. In April of 1983, the average cost per patient receiving cephalosporins at our hospital was \$40.00. By May of 1986, the average cost per patient was \$92.00. Our hospital spends more than half of our total antibiotic budget for cephalosporins. These considerations led us, in April 1983, to undertake a hospital physician education program to affect cephalosporin prescribing habits.

Background

Saint Anthony Hospital (SAH) is a 684-bed community hospital with an average of 1,300 to 1,400 discharges per month. Thirty-three percent of the

patients discharged from SAH in April 1983 had received cephalosporins at a cost of over \$22,000. Thirty-nine percent of these patients had received first-generation cephalosporins, 50% received second-generation, and 11% received third-generation. Much of the use of second-generation cephalosporins was for surgical prophylaxis, despite a consensus among experts that the less expensive and more effective first-generation agents are superior.¹

The average patient given cephalosporins received 7.7 grams at a cost of \$5.80 per gram. Cephalosporins as antimicrobial surgical prophylaxis were used an average duration of 166 hours. First-generation cephalosporins were underutilized and often given incorrectly (eg, cefazolin every 4 hours). Our antibiotic use review program was designed to determine if cephalosporins were used appropriately and cost-effectively. The hospital did not have a restrictive formulary, nor plans to implement one at the time this program was begun.

Second- and Third-Generation Cephalosporin Audits

A series of antibiotic audits was begun in July of 1983. The first antibiotic audit examined the use of second- and third-generation cephalosporins in surgical prophylaxis (Fig 1). Our standards for antimicrobial prophylaxis in surgery were the same as those

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Second- and Third-Generation Cephalosporins in Surgical Prophylaxis — July 1983

Design:	Chart review of all patients receiving the agents as surgical prophylaxis.		
Exclusions:	All OB-GYN patients. All patients in whom active infection could be identified prior to or at surgery.		
No. Studies:	88 patients with 90 surgeries.		
Antibiotics Used:	Moxalactam (8) Cefotaxime (3)	Cefoxitin (2) Cefamandole (77)	
Results:	Avg. Age: 62.5 years Sex: 54/88 male Drug started > 2 hours pre-op: 62/90 (69%) Drug started after surgery: 17/90 (19%) Average duration of therapy: 123.1 hours* Average amount parenteral drug: 13.3 grams No. also given oral antibiotic: 56/90 (62%) No. given 2nd parenteral Rx: 37/90 (41%) Op. site post-op infections: 0 Other post-op infections: 4/90 (4%)		
Cost†:	Per Month:	\$36,340	
	Per Year:	\$436,080	
	Per Patient	\$404	
	Average Patient Bill:	\$12,505	
	% cost of prophylaxis:	\$3.75	
	Cost if Cefazolin were used:	\$18,041/mo.	
	(2G once, then 1G q 8h x 48h):	\$200/pt.	

*Included oral cephalosporins

†Billed charged to patients

Figure 1.

reviewed by DiPiro et al.¹ Obstetrical and gynecological patients were excluded from the study since cefoxitin is an appropriate prophylactic agent in some types of OB-GYN surgery.¹

Hospital-wide educational programs were begun in

the fall of 1983. These included conferences given by the hospital epidemiologist, presentations at medical department meetings, pharmacy bulletins, posters over surgical scrub sinks and in surgical areas, personal visits, phone calls, and letters to selected

Table 1. Second- and Third-Generation Cephalosporins as Surgical Prophylaxis

	Number of Surgeries Reviewed	Percentage of Total Surgeries	Duration of Therapy	Grams Parenteral Used	Drug Started Post-op
7/83	88	10.5	123 hrs.	13.3	19%
11/84	87	10.1	67 hrs.	6.4	5%
7/85	26	3.0	49 hrs.	9.2	58%

Table 2. Second- and Third-Generation Cephalosporins as Surgical Prophylaxis

	% Given 2nd Parenteral Antibiotic	% Given Oral Therapy	% Given 2nd Generation Cephalosporin	% Post-Op Infection	Cost/Patient	% Total Bill
7/83	34	62	90	0	\$404	3.75
11/84	24	36	80	1	\$261	2.75
7/85	19	50	54	0	\$271	4.95

Table 3. Cefazolin Used As Prophylaxis

	8/84	7/85
Number of surgeries:	146	217
Percent of total surgeries:	14%	
Mean duration prophylaxis (hours):	37	39
Mean number of doses:	7.0	5.9
Percent of regimens started post-op:	Not determined	24%
Percent given a 2nd antibiotic:	44%	24%
Patient's mean billed antibiotic cost:	\$189	\$156
Percent of patients' total bill:	2.3%	1.6%

physicians and division heads. The most effective control measure employed was the revision of all preprinted preoperative and postoperative "standing orders." These were rewritten with consent of the involved physicians to include appropriate antibiotic agents, timing, and duration of therapy. Anesthesiologists were contacted to ensure that prophylaxis was started prior to the operative procedure, that intraoperative antibiotics were used appropriately, and that two or more different drugs were not given concurrently for prophylaxis.

Cefazolin Audits

In our examination of second- and third-generation cephalosporin usage, we also noted the incorrect use of first-generation agents. This prompted a study of cefazolin use. The charts of all patients receiving cefazolin during August 1984 and July 1985 were retrospectively reviewed. Data concerning the purpose, timing, and duration of therapy, the presence of infection, and the cost of all antibiotics used were collected. Those patients receiving cefazolin as prophylaxis in Class I and Class II surgeries² were analyzed in the same manner as those receiving second- and third-generation cephalosporins (Tables 3 and 4).

The patient charge for cefazolin in cases studied was \$35,105 during August 1985. If cefazolin had been prescribed according to the study criteria (1 g every 8 hours), total patient charges would have been reduced 36% (to \$22,600/month).

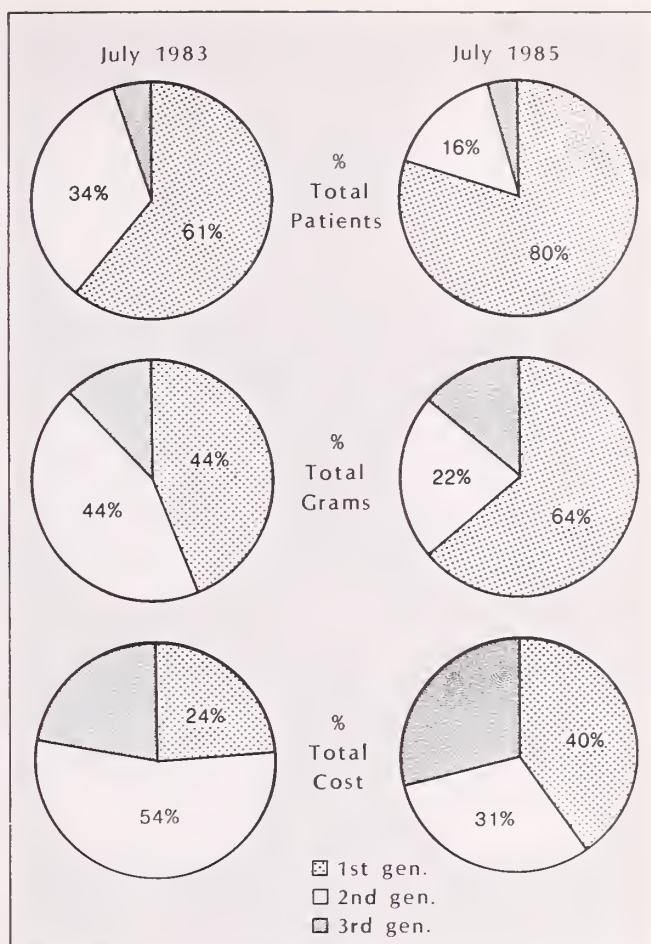


Figure 2. Cephalosporin usage patterns at Saint Anthony Hospital.

Discussion

Antibiotic audits followed by educational programs significantly improved the pattern of cephalosporin usage at our hospital (Figs 2 and 3) and indirectly improved patient care. As Hendeles pointed out in 1976, the inappropriate use of antibiotics may be due to three things: (1) the influence of the pharmaceutical industry, (2) inadequacy of physician education in this area, and (3) excessive patient demands.³

Through education alone we reduced dosing errors and the use of second-generation cephalosporins as prophylaxis, and secondarily, our hospital held cephalosporin costs to near 1983 levels.

Table 4. Total Cefazolin Use

	# of Patients	Prophylaxis (%)	Dose Frequency (%)				Medicare (%)	Preprinted Orders (%)
			q4h	q6h	q8h	once		
8/84	167	87.4	17	47	13	19	37	17
7/85	248	87.5	2	29	48	19	34	20

Percentage of Grams of Cephalosporin Used By Generation

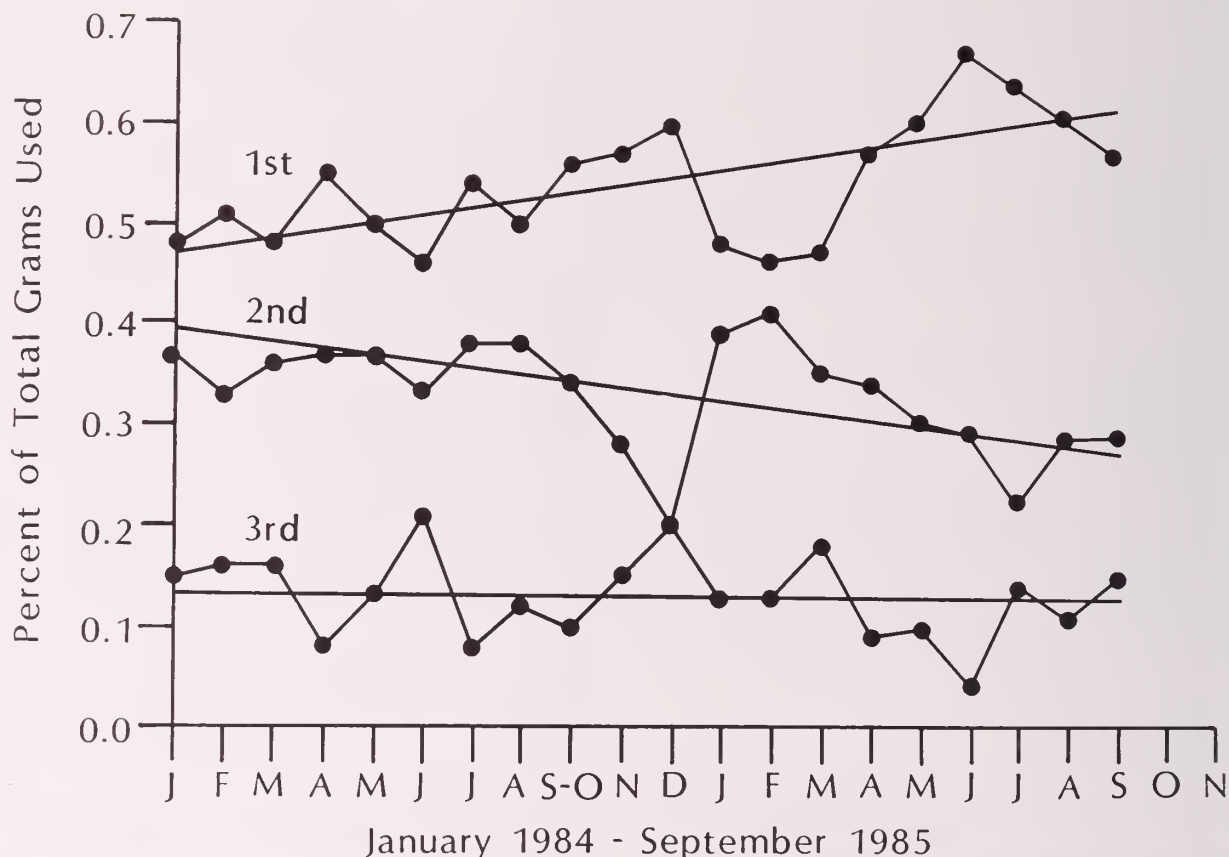


Figure 3. Graphic representation of changes in cephalosporin usage during educational program.

Injectable cephalosporins cost approximately \$260,000 in 1983; \$250,000 in 1984; and \$280,000 in 1985. If the antibiotic usage had continued in the same pattern as 1983, cephalosporins would have cost \$315,000 in 1985.

By the end of this program, our hospital formulary for injectable cephalosporins contained 12 separate drug entities (a restricted formulary of 5 cephalosporins was implemented January 1, 1987). When this education program began, 9 injectable cephalosporins were in use, and second- and third-generation cephalosporins were commonly used as prophylaxis. The average cost per gram of cephalosporin was \$2.68, \$6.11, and \$9.68 for first-, second-, and third-generation agents, respectively, in 1983. In 1986, these costs averaged \$2.91, \$7.93 and \$13.01. Actual drug cost per gram rose slightly, but by increasing the use of less costly first-generation agents we controlled this rise in cost. While our hospital census declined slightly, the percentage of

patients receiving cephalosporins rose from 32% to 35%, probably due to the changes in admission criteria induced by changes in Medicare and third-party reimbursement.

Education can effectively change drug usage patterns.⁴⁻⁹ Formulary restriction is a second means of reducing drug costs and improving appropriateness of drug therapy.¹⁰ At the time our program began, formulary restriction was not acceptable to our staff of private physicians. However, even with the success of this educational program, current financial pressures and the increasing number of available antibiotics necessitated the use of formulary restrictions. Six of the top ten drugs ranked by acquisition cost at our hospital were cephalosporins. Of the top ten drugs, eight were antibiotics. These eight antibiotics accounted for 23.7% (\$100,511) of our hospital's drug expenditures in the second quarter of 1986.¹¹

Printed materials such as our pharmacy bulletin

tins, published audit reports, and posters in surgery influenced how our physician staff utilized cephalosporins. However, a larger effect on prescribing habits was seen when these printed materials were reinforced with individual "counter-detailing" or educational visits. These same results were noted in a recent study comparing mailed "unadvertisements" with personal educational visits.¹² The most effective solution to our problems with antimicrobial surgical prophylaxis was the re-writing of surgical orders. Although cost savings were a positive result of this program, the most important outcome was a reduction in dosage errors and better choice and timing of prophylactic antibiotics.

Summary

Antimicrobial prophylaxis in surgery was often administered improperly at our hospital. First-, second-, and third-generation cephalosporin usage was suboptimal. Specific deficiencies were identified through a series of audits. Educational measures short of formulary restrictions were employed, resulting in a substantial cost savings to our patients and our hospital (for prospectively reimbursed patients).



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From the AMA Board of Trustees, June 1987

Prevention and Control of AIDS — An Interim Report

This report is being published in order to increase its visibility and facilitate its distribution throughout Oklahoma's medical community. Its publication is in keeping with the JOURNAL's intent to devote appropriate attention to the challenges facing physicians, public health agencies, and patients in dealing with the AIDS epidemic.

In future issues, the JOURNAL will be providing periodic updates, information about an AIDS hotline in Oklahoma, and memberships of the State Health Department's AIDS Task Force and the OSMA's ad hoc committee on AIDS. A forthcoming issue will be devoted to the subject of AIDS in an effort to achieve a more balanced and rational understanding of the responsibilities incumbent on each of us.

Responding sensitively, intelligently, and effectively to the growing AIDS crisis is one of the crucial public health problems facing the nation. Prevention and control of the disease must be an essential part of that response because there is, at present, no known cure for AIDS patients.

Recommendations in this report have as their foundation an overriding concern for a judicious balance between the well-being of HIV positive patients and the protection of the public health. These recommendations

are based upon the best information and data available at present. The AMA will continuously monitor and analyze developments in AIDS and update AMA policy and recommendations as dictated by advances in knowledge.

Education continues to be the major weapon against spread of HIV infection. Physicians should assume the leadership role in educating themselves, their patients and the public. Individuals in society also must assume responsibility for being well-informed and for actions that affect their own health and the health of others. In developing this report, the Board emphasizes the need for concerted and cooperative efforts by all members of society in the fight against AIDS. The recommendations outlined below are designed to help in successfully confronting this challenge to society's well-being.

I. BACKGROUND

A. The Current Climate

It is estimated that five to ten million people are infected with HIV virus worldwide. AIDS has been reported in more than one hundred countries. In the United States HIV-infected individuals may number one and one-half (1.5) million, approximately 35,000 of whom have been reported to suffer from AIDS and more than 20,000 of whom are dead.

The U.S. Public Health Service has projected that by 1991 there may be 323,000 reported patients with AIDS and as many as 200,000 of them may be dead by that time. In addition, conversion rates of seropositive people to AIDS status now appear to be higher than early preliminary estimates. Originally under 20% were thought to convert. It now appears that, without treatment advances, a much higher percentage will develop the disease.

American Medical Association, Report of the Board of Trustees, Report YY, A-87, presented by Alan R. Nelson, MD, chairman, and referred to Reference Committee E, Alfred J. Clementi, MD, chairman. AMA Annual Meeting, Chicago, June 1987.

Seventeen percent of the AIDS cases have been intravenous drug abusers; 66% have been homosexual/bisexual men; 8% have been homosexual male IV drug users; female, heterosexual male, and pediatric victims infected by the transfusion of blood or blood products, sexual contact, or prenatally in the case of infants, account for the bulk of the balance.

Polls indicate that AIDS has become the highest priority health concern of the American public, ahead of heart disease and cancer. It has already caused changes in a variety of public attitudes. Sexual abstinence, monogamous relationships, and the use of condoms are being widely promoted in the media by public officials and many private organizations. IV drug abusers are being counseled to use clean needles and to avoid sharing needles. Education on the sexual transmission of the AIDS virus is being extended to school children. The nation is more sensitive to the rights of those afflicted with the disease to be free from discrimination, regardless of the manner by which they became infected.

B. Historical Control Measures for Infectious Diseases

A primary mode of transmission of AIDS is through sexual contact, and the control efforts for sexually transmitted diseases (STD) that have been instituted in the past are sources of analogies for prevention and control of AIDS. National programs to control STDs were established during the beginning of World War I. For the following 50 years the focus was almost exclusively on the control of syphilis and its complications. During World War II rapid treatment centers for syphilis and gonorrhea were established. Public health officials instituted limited contact-tracing, had the authority to close sex bars and clubs, to order tests for prostitutes, and, most importantly, had effective therapy to offer. Widespread availability of penicillin led to the dissolution of the rapid treatment centers and of the clinical speciality, syphilology. Every state in the Union at one time required all persons seeking marriage licenses to be tested for syphilis. During the 1950s and 1960s federal assistance programs continued to support contact-tracing, serological screening, and patient education.

In the late 1960s public health officials were concerned about the rapidly escalating cases of gonorrhea, and projects were instituted to increase case-finding and contact-tracing. In 1972 financial assistance for STD control by the federal government was dramatically increased and by 1982 gonorrhea accounted for nearly three-fourths of the federal STD dollar. During the 1970s gonorrhea control efforts evolved through overlapping phases that included objectives to lower disease incidence and the occurrence of drug-resistant bacteria, focused screening on high-risk patients, intensified follow-up of treatment failures, and used patient counseling as a means of increasing compliance with therapy and improving contact-tracing. The latter was deemed especially important since the large numbers of gonorrhea cases precluded the intensive follow-up of each infected case that had been characteristic of the syphilis era.

In 1982 the World Health Organization/Pan American Health Organization (WHO/PAHO) identified the

following key objectives for intervention to reduce STDs:

1. To minimize disease exposure by reducing sexual intercourse with persons who have a high probability of infection.
2. To prevent infection by increasing the use of condoms or other prophylactic barriers.
3. To detect and cure disease by implementing screening programs, providing effective diagnostic and treatment facilities, and promoting health-seeking behaviors.
4. To limit complications of infections by providing early treatment to symptomatic and asymptomatic infected individuals.
5. To limit disease transmission within the community through the above efforts.

These objectives were used as a framework for the current United States program regarding STDs, which consists of the following components:

1. Health education and promotion.
2. Disease detection through testing and other means.
3. Appropriate treatment.
4. Contact tracing and patient counseling.
5. Clinical services.
6. Training.
7. Research.

C. The Challenge of AIDS Control

It might seem reasonable to extend the experience in preventing the spread of other STD infections to AIDS. The objectives established by WHO/PAHO and the components of the current national STD program are certainly applicable to AIDS. However, AIDS presents a much different social problem than other STD infections. Since there is no cure for AIDS and no protection beyond avoiding or making safer intimate contact with infected individuals, those infected with the virus must be sexually isolated from uninfected persons. A condom barrier offers some but not complete protection. Avoidance of sexual contact and use of shared needles are the only sure protections.

Further, the stigma that accompanies a diagnosis of AIDS, based on fear and society's attitude toward IV drug abusers and homosexuals, presents a factor beyond the control of the infected individual or medicine. An HIV-seropositive individual who might live five years or much longer with no overt health problems, once identified in a community, may be subject to many and varied discriminations—by family and loved ones, by neighbors and friends, by employers and fellow employees, and by other providers of services.

As with prevention and control of all contagious diseases, prevention and control of AIDS involves two, sometimes competing, concerns. First, the person who is afflicted with the disease needs compassionate treatment, and both those who have the disease and those who have been infected with the virus should not be subjected to irrational discrimination based on fear, prejudice or stereotype. Second, and of critical importance, the uninfected must be protected; those individuals who are not infected with the AIDS virus must have every opportunity to avoid transmission of the disease to them.

II. THE NEED FOR A NATIONAL POLICY ON AIDS

Given the growing dimensions of the crisis and given limited national resources, it is imperative that a national policy be developed jointly by the public and private sectors. Such a policy must seek, in a cost-effective way, to achieve fundamental national goals: prevention, treatment, and cure — and adequate research in all three areas. A coherent national approach to this modern killer is needed: a comprehensive blue print for a national response, not piecemeal solutions. Knowledge of the disease is now more than six years old and the growing magnitude of the problem has been apparent for nearly that long.

Such a national policy must have certain characteristics:

- The policy must be comprehensive, proceeding simultaneously on the fronts of prevention, treatment, and research.
- The policy must be coordinated between public and private sectors and between the different levels of government. A national policy does not necessarily mean a federal policy: there are important roles at all levels of the health care systems and at all levels of government. Nor does it necessarily mean uniformity: on certain issues different approaches should be tried to determine efficacy.
- The policy must be carefully balanced. For example, concern for the person with the disease must be balanced with concern for those who do not have the disease but who may become infected. Similarly, careful consideration must be given to directing scarce resources to increased prevention, even as increasingly large resources are necessarily devoted to research and treatment.
- The policy must be based on scientific information and medical judgments. Although policy choices must inevitably be made, they should be formed on the best available information and on the extensive public health experience in dealing both with AIDS and with other contagious diseases.
- The policy should be nonpartisan. Although it may be tempting to play on fears and prejudices, public figures and officials both inside and outside the health community should avoid exploiting the crisis for partisan political advantage.
- The policy should be capable of continuous review and modification as more and better information becomes available.

Recommendation 1:

A Commission, modeled after the commission which made recommendations on the problems of Social Security financing in the early 1980s, should be constituted with representatives from the Executive branch of the federal government, the Congress, state and local government, and the private sector and directed to develop a consensus position for consideration by the Congress, the Executive, state and local

governments and private associations and institutions. The presidential commission announced, but not yet appointed, by the Administration could be broadened to implement this recommendation. A high-level body with representatives from the different branches and levels of government, but operating to the side of the more formal political processes, may have the best chance of forging the necessary national consensus which can then become the basis for concerted and coordinated action by both the public and private sectors.

III. THE SPECIAL ROLE OF PHYSICIANS AND OTHER CARE COUNSELORS

Because there is no cure for AIDS, effective preventative techniques are vital. This involves both those who are infected and those who are not. Those who are infected must be identified so that they will not unknowingly transmit the disease to others. Many who are not infected will need to change their behavior substantially to minimize their risk of infection by the AIDS virus.

The key to changed behavior is public education coupled with counseling which must be given by physicians and other health care counselors.

A. Public Awareness

The public is well aware of AIDS in a general sense. The attention of the media has been intensively focused on the disease. Translating general awareness into modifications of behavior is the challenge.

The groups that are most at risk for AIDS, e.g., IV drug abusers, homosexuals, bisexuals, and prostitutes, have reason to know they are at risk. Their contacts, however, may not know they are at risk and hence spouses, unborn babies, and premarital and extramarital sexual partners may become infected. Education and counseling aimed at the high-risk groups must be the first priority. The education should urge immediate counseling with a physician or other health care counselor about the risk of AIDS, the uses of antibody testing and preventive measures.

Also, it must be recognized that persons in these groups may not respond to education and counseling and, when they do not, more aggressive programs — such as expanded methadone maintenance programs or penalties for knowingly exposing others — must be considered.

Education aimed at the more general population is difficult for at least two reasons. First, reaching all Americans with an effective message can be expensive and not all people respond in the same way or to the same method of learning. Messages must therefore be tailored to the target audience in question. Second, preventive messages must necessarily deal with controversial subject matter. Widespread use of the electronic media — especially television — appears to be the most effective way to reach the general public. Accordingly, public service advertising on the electronic media must be greatly increased and these announcements must be shown at times and in places where they will be viewed by those who need the message most.

The AMA will continue its efforts to place its own public service ads on national television. AMA's Tony Danza

public service advertisement (PSA) directed at teenagers about abstinence and condoms, and other PSAs which the networks have agreed to use, are significant first steps. But, more must be done and it must be nationally coordinated.

Recommendation 2:

The communications industry must develop voluntary guidelines for public service advertising regarding AIDS in consultation with the health care community and government officials. The AMA intends to be a catalyst in this effort to immediately bring the communications and health care communities together.

B. Counseling—And Educating Counselors

Perhaps the greatest need at the present time is effective counseling of both low-risk and high-risk populations by physicians or other health care counselors. A massive education effort for physicians and other counselors is necessary as a first step. Complete and accurate information on the disease, the modes of transmission, the appropriate application of antibody testing, and effective ways to change behavior must be understood by counselors if it is to be properly communicated to patients. In conjunction with face-to-face counseling, printed materials — like the Surgeon General's recent 36-page report on AIDS — should be widely disseminated.

Even more challenging than preparing physicians and others for generic counseling on AIDS is preparing these counselors to assist those who test positive and are infected with the virus. It is at that time that a change of behavior on the part of the person infected is most critical, and it is then that the most sophisticated counseling is required due to the emotional impact of the test results. There is no higher prevention priority than ensuring that the community of individuals who provide health care counseling be given adequate tools to be effective. And the AMA, as the largest organization of physicians in the world, must take a leading role in this undertaking.

Recommendation 3:

A conference should be immediately held between the AMA, other physician organizations and public health officials at all levels of government to determine:

1. The types of education and training that are necessary for effective counseling.
2. The people in the health care community who should receive this education and training.
3. The current resources available for such education and training.
4. Recommendations for providing additional resources, including consideration of the respective roles of medical associations and government at all levels.
5. Recommendations on how to update information continually as new scientific data are developed.
6. Recommendations as to alternative measures

to prevent the spread of AIDS where education and counseling are not likely to be effective, particularly among IV drug users, through such programs as expanded methadone maintenance.

The AMA will promptly and widely report on the conference findings and assist in the implementation of the conference recommendations.

C. Voluntary and Mandatory Testing

Knowledge that a person is infected with the AIDS virus can be the crucial predicate to changing behavior. Thus, testing for an antibody to the AIDS virus, when used in conjunction with appropriate counseling (and when offered in the context of appropriate anti-discrimination and confidentiality protections discussed below), serves the important public health purpose of providing impetus for behavior changes that minimize the risk of transmitting the AIDS virus.

Clearly, the need for HIV-antibody testing has expanded beyond its original purpose, the screening of blood donors. Guidelines for the appropriate use of HIV-antibody testing must center on the following justifications:

1. To identify infected persons and to offer treatment where possible and to protect uninfected third parties.
2. To offer education and counseling that would modify high risk behavior.
3. To solicit patient cooperation for locating and referring sex partners.
4. To obtain broadened epidemiological statistics on the prevalence of HIV infection in the population.

In addition, in considering the merits of voluntary versus mandatory testing, these facts about AIDS must be kept in mind:

1. AIDS is caused by an infectious agent, and therefore is an infectious disease. Appropriate precautions, procedures, and policies should be applied to protect the community from the spread of the disease.
2. The extent to which the AIDS virus already has spread into the general population is not completely understood. Current projections are based on a number of unverified assumptions.
3. The transmission of the AIDS virus does not occur through casual contacts. Sexual contact, septic intravenous equipment, and the administration of infected blood and blood products are the main modes of transmission.
4. Heterosexual transmission of the AIDS virus, especially from males to females, does occur.
5. Seropositive pregnant females will transmit the virus to their babies in a high percentage of cases.
6. Health care workers, especially those who perform invasive surgical procedures, and emergency room and laboratory personnel,

are at some risk when caring for AIDS patients.

7. No patient with a clinical case of AIDS has survived the disease. The disease has been uniformly fatal.
8. The disease, not its victims, is the threat from which society must be protected.
9. The confidentiality of the doctor-patient relationship is vitally important but not absolute.
10. Physicians have an ethical and professional obligation to behave in a scientifically responsible manner.

All of these considerations guided the Board of Trustees as it considered the issues that have been raised by the wide variety of proposals for HIV-antibody testing that are being discussed in society.

General Conclusions

Except for individuals in the limited categories listed in Recommendation 5 below (blood, organ and semen donors, immigrants, military personnel, prison inmates) with regard to whom testing serves well-established and well-accepted protection goals, mandatory national testing should not, at present, be broadly extended.

Military personnel have traditionally been subject to mandatory immunizations and our defense forces, of course, must be as strong as possible. Prison inmates, because they are confined and have a higher incidence of high-risk individuals than the general population, require special protection. Immigrants should be tested so that we can focus on the AIDS problem already here, and the nation certainly has the right to bar entrants with communicable diseases. The need to test donors of blood, organs and semen has never been questioned.

Public health authorities have advanced a plausible premise for their opposition to mandatory testing of homosexuals and drug abusers: such testing will only drive people underground and away from the health care system. Public health authorities also have advanced a premise for not requiring mandatory testing of large segments of the general population, such as all those seeking marriage licenses or all those admitted to hospitals: such testing in low prevalence populations would result in a high proportion of false positives, and would not be cost-effective, given the demand for voluntary testing and the shortage of testing and counseling resources for those who want them voluntarily or who will want them following effective public awareness campaigns.

Until those premises are shown by superior studies to be incorrect, a policy regarding mandatory testing which has been rejected by the vast majority of public health officials, including the Centers for Disease Control and the Surgeon General, cannot be recommended.

But certain high risk groups should be regularly tested, with a right to informed consent and to refuse the test. Those groups are defined in Recommendation 6.

In addition, physicians and other hospital personnel involved in invasive surgical procedures who necessarily and unavoidably come in contact with the blood of patients, need to be aware of their risks. Limited regular testing of patients will assure that the CDC guidelines for the protection of hospital personnel are followed rigorously and

will further assure that all patients receive prompt and full treatment. The Board emphasizes here that physicians have a long and honored tradition of tending to patients afflicted with infectious diseases with compassion and courage. That tradition must and will be continued throughout the AIDS epidemic.

Because the risk to health care personnel will be slight in most areas, any effort at mandatory testing of certain kinds of patients should be instituted after voluntary testing has failed and where a variety of factors, *e.g.* the costs and availability of proper testing and counseling as measured against the risk presented by the relative presence of a high risk patient population, weigh in favor of mandatory testing.

The AMA does not believe it appropriate at this time to extend regularly offered testing to persons other than those listed, *e.g.*, recommended testing should not be extended to all individuals anywhere who are considering marriage or to all persons in hospitals. Decisions about whether there should be generally recommended testing to other types of individuals should, at this time, be left to the decision of the local community depending on its own circumstances and the judgments of its own public health officials.

At present, each case of AIDS must be reported by the individual physician to state public health authorities either by name or identifier. Anonymous, or if carefully implemented, confidential reporting should also be extended to all confirmed instances of persons infected with AIDS virus but not afflicted with ARC or AIDS. Individuals who are seropositive for the HIV antibody are infected with the virus and can spread the disease as certainly as those with symptoms of AIDS. A sound epidemiologic understanding of the potential impact of AIDS on society requires the reporting of those who are confirmed as testing positive for the antibody to the AIDS virus.

Testing Recommendations

Recommendation 4:

Tests for the AIDS virus should be readily available to all who wish to be tested. The tests should be routinely subsidized for individuals who cannot afford to pay the cost of their test.

Recommendation 5:

Testing for the AIDS virus should be mandatory for donors of blood and blood fractions, organs and other tissues intended for transplantation in the U.S. or abroad, for donors of semen or ova collected for artificial insemination or in vitro fertilization, for immigrants to the United States, for inmates in federal and state prisons and for military personnel.

Recommendation 6:

Voluntary testing should be regularly provided for the following types of individuals who give an informed consent:

1. Patients at sexually transmitted disease clinics.
2. Patients at drug abuse clinics.
3. Pregnant women in high risk areas in the first trimester of pregnancy.
4. Individuals who are from areas with a high

incidence of AIDS or who engage in high-risk behavior seeking family planning services.

5. Patients who are from areas with a high incidence of AIDS or who engage in high risk behavior regarding surgical or other invasive procedures. If the voluntary policy is not sufficiently accepted, the hospital and medical staff should consider a mandatory program for the institution.

Recommendation 7:

As a matter of medical judgment, physicians should encourage voluntary HIV testing for individuals whose history or clinical status warrant this measure.

Recommendation 8:

Individuals who are found to be seropositive for the AIDS virus should be reported to appropriate public health officials on an anonymous or confidential basis with enough information to be epidemiologically significant.

Recommendation 9:

Physicians should counsel patients before tests for AIDS to educate them about effective behaviors to avoid the risk of AIDS for themselves and others. In public screening programs, counseling may be done in whatever form is appropriate given the resources and personnel available as long as effective counseling is provided.

Recommendation 10:

Physicians should counsel their patients who are found to be seropositive regarding (a) responsible behavior to prevent the spread of the disease, (b) strategies for health protection with a compromised immune system, and (c) the necessity of alerting sexual contacts, past (5-10 years) and present, regarding their possible infection by the AIDS virus. Long-term emotional support should be provided or arranged for seropositive individuals.

Recommendation 11:

Patients should knowingly and willingly give consent before a voluntary test is conducted.

IV. RESOURCES

Only recently has Congress and the Administration begun to seriously consider the vast resources needed to deal effectively with AIDS. Federal funding for 1988 is expected to reach \$1 billion. But that amount will not be enough. The AMA endorses the bill introduced by Congressman Waxman to increase resources for testing and counseling.

Testing for the HIV virus in America will require substantially more resources than are currently being made available. Trained counselors, materials for counseling, and research on effective counseling approaches, for the variety of population groups that need these services, are urgently required. Also, dependable testing facilities with sufficient capacity to respond to the epidemic are needed now. In addition, funds for research

and care must be increased to fully exploit the nation's capacity to respond effectively to this crisis.

The key premise of a prevention strategy, when there is no vaccine, is behavioral change on the part of those infected and those at risk of infection by AIDS virus. It is therefore crucial that there be immediate and systematic studies conducted of how behavior of affected groups may have changed in recent years, and if possible, what factors caused the changes. Most particularly, it is necessary to study and evaluate the types of counseling that have been effective so that the techniques may be replicated widely. There can be little question that in a free society suasion and voluntary change, if effective, are far preferable to compulsion.

Recommendation 12:

Public funding must be provided in an amount sufficient (1) to promptly and efficiently counsel and test for AIDS (2) to conduct the research necessary to find a cure and develop an effective vaccine, (3) to perform studies to evaluate the efficiency of counseling and education programs on changing behavior and (4) to assist in the care of AIDS patients who cannot afford proper care or who cannot find appropriate facilities for treatment and care.

V. PROTECTION AGAINST DISCRIMINATION

A. Anti-Discrimination

The AMA believes strongly that AIDS victims and those who test positively for the antibody to the AIDS virus should not be treated unfairly or suffer from arbitrary or irrational discrimination in their daily lives. Last year, the AMA filed a friend of the court brief in *School Board of Nassau County v. Arline*, a case before the Supreme Court which addressed the question of how the federal handicapped anti-discrimination laws should apply to persons afflicted with contagious diseases. The AMA set forth a framework for the application of the law which the Supreme Court adopted, quoting verbatim from the AMA brief in its key holding.

A sound anti-discrimination approach does not allow reflexive discrimination against AIDS victims based on fear or stereotype or prejudice. Nor does it require that all employers or other federal fund recipients automatically accommodate a person afflicted with a communicable disease. Instead, based on an individualized analysis of the nature and duration of the handicap and the nature and duration of the communicability, a federal fund recipient must make a reasonable accommodation based on reasonable medical judgments, given the state of medical knowledge at the time. This sound framework for carefully balancing the two competing concerns — the right of the victim to be free from irrational acts of prejudice and the right of others to be protected against an unreasonable risk from disease — should also guide state anti-discrimination efforts.

A key question left open by the Supreme Court is whether a person who is not afflicted with AIDS or AIDS Related Complex, but who nonetheless tests positive for the antibody, is protected by the federal anti-discrimination law.

In order to encourage people to seek counseling, and testing if necessary, the AMA strongly urges that anti-discrimination laws at both the federal and state levels be clarified either by regulatory interpretation or statutory amendment to cover those who test HIV antibody positive. Allowing irrational discrimination against those who test positive serves no useful purpose: it only has the destructive effect of removing those who are otherwise productive members of society from the work force or otherwise denying them access to an important aspect of normal life. While the federal law should continue to apply only to federal fund recipients, state laws should be sought to prevent irrational discrimination by entities or individuals within those jurisdictions.

Recommendation 13:

Anti-discrimination laws must be clarified or amended to cover those who test positive for the antibodies to the AIDS virus.

B. Confidentiality

The ability of the health care community to maintain the confidentiality of patient information and restrict its use to only those purposes essential for maintenance of health is, like clarification of anti-discrimination laws, vital to an effective program of preventing and controlling AIDS. Even if antidiscrimination laws were completely effective, which unfortunately is not likely, persons who test positive (such as those with ARC or AIDS), will suffer stigma. Thus, confidentiality is crucial.

The basic principle should be that access to patient information should be limited only to health care personnel who have a legitimate need to have access to the information in order to assist the patient or to protect the health of others closely associated with the patient.

As with anti-discrimination laws, laws protecting the confidentiality of patient information should be on both federal and state agendas.

Recommendation 14:

Model confidentiality laws must be drafted which can be adopted at all levels of government to encourage as much uniformity as possible in protecting the identity of AIDS patients and carriers, except where the public health requires otherwise.

VI. QUESTIONS FOR THE FUTURE

As the national debate on prevention and control of AIDS continues, other important issues will need to be addressed.

A. Research and Data

There is an urgent and critical need for more scientifically sound data on the prevalence and spread of virus in the general population. At the present time only those cases that meet the current CDC surveillance definition of AIDS are reported to that institution. Since AIDS is the terminal and fatal stage of HIV-infection, it represents only the tip of the huge HIV-infection iceberg. There are protean manifestations of HIV-infection ranging

from infected asymptomatic to full-blown AIDS. How large the base of that iceberg really is — that is, how many people are actually infected — can only be estimated from the number of reported AIDS cases. That has been done by using a multiple (50 to 100 times the number of AIDS cases) that has been extracted largely from surveys done in high-prevalence areas. Yet this same multiple has been used to estimate the number of current and potential HIV-infected persons in low-prevalence areas and for that matter the entire country and even the world. The CDC itself is unsure about the accuracy of its estimates. Yet if economic and medical plans are to be made for the future, reliable projections must be available. How sufficient or exaggerated these plans may be depends upon the accuracy of current and future estimates of HIV-infected persons, particularly as to the extent of its spread into the low-risk heterosexual population.

Not only are accurate estimates of HIV-infected persons needed, but so too are reliable data on the rate of conversion asymptomatic seropositive persons to clinical illness, including AIDS, that requires increased medical care. This information is important for the formulation of plans for the future cases of potentially hospitalizable patients and the economic consideration thereof. HIV-infection has protean manifestations and death can result not only from AIDS itself, but from severe ARC or progressive CNS disease as well. In order to obtain accurate information in HIV infected persons on the rate of conversion from asymptomatic to clinically severe illness, baseline data on their serologic status must be obtained as early as possible — not after clinically manifest disease is present. The presence of HIV antibodies indicates not only current infection with the virus, but also that the patient is potentially capable of transmitting the disease. This follows from the fact that HIV integrates its genome into the host cell genome with the result that once infected, the patient remains infected for life and is, therefore, capable of life-long transmission of the agent. The earlier the infected person is detected, the earlier he or she may be advised of this contagious state and counseled on how to avoid further transmission of this lethal virus.

Recommendation 15:

Consistent with the proposal by the Secretary of Health and Human Services, a national study in various areas of the country must be immediately undertaken to determine the prevalence and conversion rate of the virus in the United States population, and the study must be repeated at appropriate intervals to gauge the spread of the disease.

B. Warning to Third Parties

One of the more difficult issues for society is how to warn unsuspecting spouses or sexual partners of persons who test HIV positive. Such a warning would allow the third party to practice "safer" sex or to abstain from sexual relations with the infected person altogether. Given the life-or-death consequences, the unsuspecting third party should, as a general matter, be warned because there is no cure and because it may not be responsible to rely solely on the infected person to provide a suitable warning.

Physicians who have reason to believe that there is an unsuspecting sexual partner of an infected individual should be encouraged to inform public health authorities. The duty to warn the unsuspecting sexual partner should then reside in the public health authorities as well as the infected person and not in the physician to the infected person.

The AMA believes that mechanisms, analogous to those used by public health authorities to warn sexual partners about other sexually transmitted diseases, should be put in place to warn unsuspecting third parties about an infected sexual partner. Such warning may be appropriate whether the infected person is bisexual, heterosexual or homosexual.

This problem raises the general question of whether anonymous reporting should continue to be the standard for persons who test seropositive. Our recommendation at this time is limited to situations where physicians or health officials already know the identity of the AIDS carrier and have reason to believe a risk to third parties exists.

Recommendation 16:

Specific statutes must be drafted which, while protecting to the greatest extent possible the confidentiality of patient information, (a) provide a method for warning unsuspecting sexual partners, (b) protect physicians from liability for failure to warn the unsuspecting third party but (c) establish clear standards for when a physician should inform the

public health authorities, and (d) provide clear guidelines for public health authorities who need to trace the unsuspecting sexual partners of the infected person.

C. Sanctions for Reckless Disregard for the Safety of Others

A related question which must be explored is whether an infected person, who knows he or she is infected and who knowingly fails to warn a sexual partner of the infection, should be subject not just to tort suits, but to a proceeding brought by state authorities to sanction the individual.

Recommendation 17:

Given the risk of infection being transmitted sexually, and given the dire potential consequences of transmission, serious consideration should be given to sanctions, at least in circumstances where an unsuspecting sexual partner subsequently finds out about a partner's infection and brings a complaint to the attention of authorities. Pre-emptive sanctions are not being endorsed by this recommendation.

Conclusion

The Board intends to review its evaluation of the developing AIDS epidemic on a constant basis. Modifications of the AMA's positions will be made as the situation warrants. □

Leiomyoma of the Fourth Part of the Duodenum

PANOS G. DELIKARIS, MD; JOHAN POULSEN, MD; I. BALSLEV, MD

Benign tumors of the small intestine represent a rare entity. According to the largest reported series, the duodenum ranks third in decreasing order of incidence.^{8,10} On the other hand, when its shorter length is taken into consideration, the duodenum becomes the most frequent site per unit of length of such lesions. Leiomyomas, in the largest reported series, are among the commonest small intestinal tumors, constituting about 20% of the benign tumors of the duodenum.

Case Report

A 61-year-old woman was admitted to the Surgical Gastroenterological Department A, Aalborg Sygehus Syd, because of a mass palpated in the left upper quadrant of the abdomen. She had no significant previous history, except that some 30 years prior to her current admission she had undergone an appendectomy and an umbilical hernioplasty. She was totally asymptomatic, and she had recently felt the mass herself when bathing. Prior to admission, a barium enema, an intravenous pyelogram, and a liver-spleen radioactive scan were normal.

On physical examination the only abnormal finding was a 10 cm × 10 cm hard, mobile mass

under the left costal margin. The tumor was not tender and its origin could not be clinically defined. Hemoglobin, sedimentation rate, white blood count, urea-creatinine, electrolytes, serum proteins, and liver function tests were normal.

On the day following her admission, the patient was submitted to an exploratory laparotomy, initiated through a transverse incision on the upper

**The fourth part
of the duodenum is
an exceptionally rare site
for . . . a leiomyoma.**

abdomen. A 20 cm × 15 cm × 10 cm solid, relatively soft, very vascular and malignant appearing tumor was found (Figs 1 and 2). The tumor was arising from the retroperitoneal duodenum, was attached to and thus elevating the pancreas, and was growing into the transverse mesocolon, strongly adhered to the superior mesenteric artery and vein.

The tumor was removed together with the third

From Surgical Gastroenterological Department A, Aalborg Sygehus Syd, Aalborg, Denmark.

Direct correspondence to Johan Poulsen, MD, Lervangen 40, DK 7120 Vejle Ø, Denmark.

and fourth parts of the duodenum, the beginning of the jejunum, and the distal segment of the pancreas. The spleen was preserved, and gastrointestinal continuity was reestablished by an end-to-end duodenojejunostomy over the superior mesenteric vessels.

The patient had an uneventful postoperative course and was discharged on the tenth day following admission.

Pathology: On histologic study, confirmed with electron microscopy, the tumor proved to be a benign leiomyoma having its origin from the muscularis propria of the fourth part of the duodenum.

Discussion

The fourth part of the duodenum is an exceptionally rare site for the development of a leiomyoma. We could find only one such case previously reported in the literature,² and from a recent collective review it became obvious that the majority of duodenal leiomyomas are found in the first and second parts (36 out of 42 reviewed cases, or 85.7%), with a slight predominance of the former (20 cases vs 16).⁶

This highly vascular duodenal leiomyoma was entirely asymptomatic until its increasing size attracted the patient's attention. This is well understood, as the tumor was extraluminal, arising from the muscularis propria and thus not interfering with the intestinal lumen patency. The alternative is usually the development of a smooth muscle tumor

from the muscularis mucosae, resulting in intraluminal growths presenting with gastrointestinal bleeding and/or obstruction.^{1,4}

The diagnosis of these tumors in the distal duodenum is a difficult task. Conventional diagnostic work-up, as conducted in our case, has proved unproductive. Angiography is the method of choice,³ but while its necessity is understood in investigations for the focus of gastrointestinal bleeding,^{5,9} its priority to the time-honored exploratory laparotomy in the presence of an abdominal mass can be doubted.

With regard to pathology, much against the gross impression of invasiveness obtained at surgery, histologic study revealed that the resected tumor was a benign leiomyoma. However, it is well established that one should be reluctant with the histological classification of smooth muscle tumors,⁷ as it is shown that clinical behavior and course, rather than histologic features, are the main criteria for the differentiation between leiomyomas and leiomyosarcomas.

Finally, as far as surgery is concerned, distal pancreatectomy with preservation of the spleen did not pose any problems. The dissection from the transverse mesocolon was relatively easy, although the viability of the corresponding colonic segment — as the middle colic vessels were severed — was momentarily challenged, imposing the necessity of an additional segmental colectomy. What has been in fact a difficult technical exercise, worth mention-

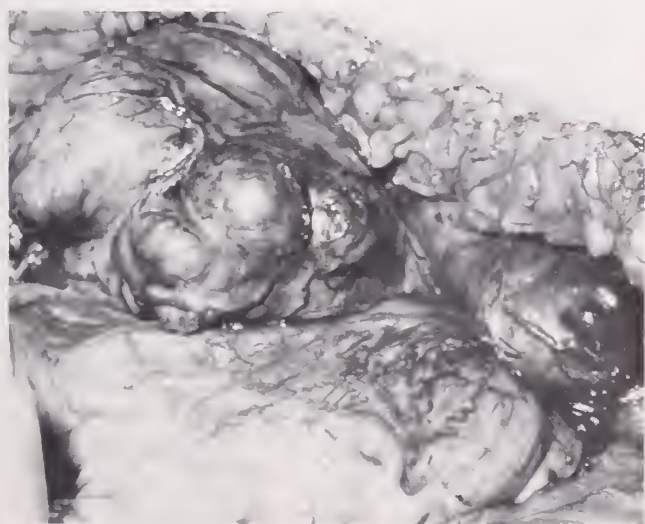


Fig 1. Operative view of the tumor seen through a transverse upper abdominal incision. Very vascular, big tumor attached to and elevating the distal portion of the pancreas.

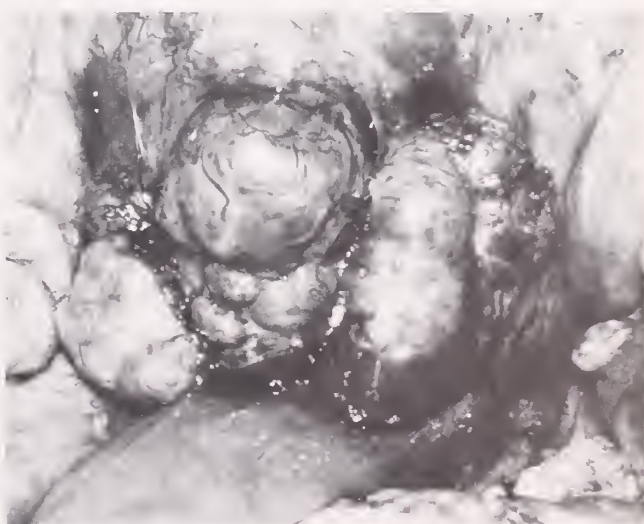


Fig 2. Operative view of the tumor from the lower abdomen following an upward displacement and retraction of the transverse colon. Very vascular, big, malignant appearing tumor arising from the retroperitoneal duodenum and growing around the transverse mesocolon.

ing, was the dissection of the tumor from the superior mesenteric vein, which, because of the high position near its confluence with the splenic vein, can occasionally render the case inoperable.

Summary

A histologically benign leiomyoma arising from the muscularis propria of the fourth part of the duodenum is described. The tumor was growing extraluminally and was asymptomatic, presenting only as a palpable abdominal mass. It was removed in total with distal pancreatectomy and resection of the retroperitoneal duodenum, after dissecting it free of the superior mesenteric artery and vein. This is an exceptionally rare localization for a leiomyoma, and its relation to the superior mesenteric vessels can occasionally render such a case inoperable. □

Note: Prior to publication, the authors were asked if an update of their report and references was indicated. No new information was submitted.

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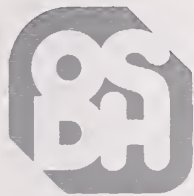
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I. Balslev, MD, is head of the gastroenterological surgery department at Aalborg Regional Hospital.

Coming in October . . .

Among the manuscripts being considered for publication in October are a paper on anorexia nervosa, an anatomy quiz, and a report from the Seventh World Congress of the International Physicians for the Prevention of Nuclear War.



Ehrlichia canis: A Cause of "Oklahoma Tick Fever"?


Each year, there are four or five times as many Oklahomans suspected of having Rocky Mountain Spotted Fever (RMSF), but ruled out by serologic test, as there are confirmed cases. Most of these persons have a history of tick bite and febrile illness consistent with a rickettsial disease. This undefined illness has been referred to as "Oklahoma Tick Fever" (OTF).

In September of 1986, the Oklahoma State Department of Health (OSDH) received information about a patient with suspected *Ehrlichia canis* infection. The patient, a 51-year-old black male, received several tick bites between March 26 and 29, 1986, while vacationing in Malvern, Ark. On April 9 he developed fever, myalgia, malaise, and headache, and was suspected of having RMSF. Serum from the patient was negative for RMSF, as well as leptospirosis, tularemia, typhus, Q-fever, and hepatitis A

and B. The presence of leukocytic cytoplasmic inclusions, later identified as *Ehrlichia* spp by electron micrograph, was noted in granulocytes and mononuclear cells. Subsequently, a high antibody titer to the species *Enrlichia canis*, a recognized pathogen in dogs, was found.

To determine if *E canis* was a cause of OTF, the OSDH began a survey of serum specimens that had been submitted for RMSF testing during 1986 and had been found to be negative for antibody to *Rickettsia rickettsii*. Of 144 paired specimens that were available for testing, 16 (11%) had a four-fold increase in antibody to *E canis*. Interviews with patients revealed the most frequent signs and symptoms to be fever, headache, anorexia, nausea, fatigue, and rash. Leukopenia (WBC 5000) and thrombocytopenia (platelets 150,000) were the most frequent laboratory abnormalities. Although none of these persons died, 6 of the 16 (37%) were hospitalized for the illness.

The diagnosis of "human ehrlichiosis" should be considered in the differential diagnosis of RMSF in Oklahomans. Serologic testing, on paired specimens taken 10 to 14 days apart, is available through the OSDH.

For further information, please contact the Epidemiology Service, Oklahoma State Department of Health, 405/271-4060. 

DISEASE	June 1987	TOTAL TO DATE		
		This Year	Last Year	5 Yr. Avg.
AMEBIASIS	1	5	4	7
CAMPYLOBACTER INFECTIONS	29	107	131	—
ENCEPHALITIS, INFECTIOUS	3	14	10	11
GIARDIA INFECTIONS	13	82	85	—
GONORRHEA (Use ODH Form 228)	723	4902	6188	6258
HAEMOPHILUS INFLUENZAE INVASIVE DISEASE	14	79	126	—
HEPATITIS A	18	155	164	228
HEPATITIS B	24	140	84	105
HEPATITIS, NON-A-NON-B	9	28	29	—
HEPATITIS UNSPECIFIED	3	20	25	65
MEASLES (RUBEOLA)	1	2	12	4
MENINGITIS, ASEPTIC	24	54	29	38
MENINGITIS, BACTERIAL (non-meningococcal, non H. Influenzae)	0	21	29	34
MENINGOCOCCAL INFECTIONS	2	17	16	18
PERTUSSIS	11	44	56	79
RABIES (Animal)	7	19	38	67
ROCKY MOUNTAIN SPOTTED FEVER	20	39	27	40
RUBELLA	0	0	0	1
SALMONELLA INFECTIONS	43	165	183	153
SHIGELLA INFECTIONS	4	95	72	102
SYPHILIS (Use ODH Form 228)	8	82	85	91
TETANUS	1	1	0	0
TUBERCULOSIS	18	106	123	111
TULAREMIA	1	8	5	4
TYPHOID FEVER	0	1	0	1

Diseases of Low Frequency	Total to Date This Year
ACQUIRED IMMUNE DEFICIENCY SYNDROME	47
BRUCELLA LEGIONNAIRES DISEASE	4
MALARIA	10
REYE SYNDROME	3
TOXIC SHOCK SYNDROME	0
	8

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Tough questions. AIDS is the subject as OSMA President Joe Crosthwait, MD, left, answers reporter Vicki Lewis's questions at a press conference in May. The conference,

held at OSMA headquarters in Oklahoma City, was designed to give local media a medically accurate picture of the deadly disease.

From the AAFP Reporter

Fear of AIDS fuels increase in health fraud and "cures"

Calling false hope "the worst form of charlatanism," a Kansas City doctor is cautioning physicians about an increasing number of medical scams and purported cures for AIDS.

According to John Renner, MD, director of medical development for St Mary's Hospital in Kansas City, Mo, fraudulent AIDS treatments now being offered include such things as "pond scum" to improve the immune system and "thumping the thymus" because, one huckster claims, "everyone knows that gorillas have super immunity systems, and gorillas thump their thymus."


In the story, which appears in the July issue of *AAFP Reporter*, Dr Renner suggests several ways in which physicians can combat such health fraud:

- Be aware of all medications, both prescription and nonprescription, that your patients are taking.

Explain to patients that alleged immune system boosters aren't effective.

- Be especially concerned about overly fearful patients, as they are most vulnerable to hucksters.

- Become a health educator; know the facts about AIDS and dispel myths about the disease.

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Be accurate and thorough

Death certificates important in tracking nation's health

Physicians have a crucial responsibility to report accurately the cause of death on death certificates, according to a report and editorial in the *Journal of the American Medical Association*. Such information provides the basis for national mortality statistics, which are used for health policy formulation, program planning and evaluation, funding, and legislation.

"Mortality statistics derived from death certificates are the only continuously collected, population-based, disease-related information available in most parts of the world, including the United States," says Tobias Kircher, MD, of Penrose Hospital, Colorado Springs, and Robert E. Anderson, MD, of the University of New Mexico, Albuquerque. They advise that physicians determine the underlying and immediate causes of death and any intervening causes, as well as the mechanism and manner of death. Since 1949, US death certificates have required the attending physician to name the immediate cause of death; to describe related, antecedent conditions; and to list other significant conditions contributing to death.

"As longevity increases in many parts of the world, so do the challenges to the physician charged with the responsibility of accurately completing the death certificate," the researchers observe, since older persons often suffer from degenerative and chronic processes that affect many body systems.

Few physicians are familiar with the processing of death certificates through state health departments and then the National Center for Health Statistics to produce mortality statistics, according to the report. "Since the statistical data derived from death certificates can be no more accurate than the information on the certificates, it is of utmost importance that all persons concerned with the registration of deaths not only strive for completeness, but also for accuracy," the researchers conclude.

Commenting editorially, Richard A. Goodman, MD, MPH, and Ruth L. Berkelman, MD, of the Centers for Disease Control, Atlanta, note that physicians' responsibilities in maintaining accurate data on the nation's health are not limited to death certificates. For more than a century, physicians have reported selected infectious diseases. "Today, reports of more than 40 infectious diseases to local and state



PLICO commendation. At the PLICO board meeting in May, Edward K. Norfleet, MD, (left) of Vinita receives a plaque of appreciation from PLICO President C. Alton Brown, MD. The special award was in recognition of Dr Norfleet's many years of service on the board.

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City of Faith


International symposium on Alzheimer's coming to Tulsa

The First International Symposium on Familial Alzheimer's Disease will be held Thursday and Friday, October 22 and 23, at the City of Faith Medical and Research Center in Tulsa.

The event, organized by the Familial Alzheimer's Disease Research Foundation, is being cosponsored by the University of Washington, Alzheimer Disease Research Center; the World Federation of Neurology; the Department of Pharmacology, Oral Roberts University School of Medicine; the University of Oklahoma Tulsa Medical College; the Hereditary Disease Foundation; and the National Institute on Aging.


Scientific sessions will include such topics as the clinical and epidemiologic aspects of Alzheimer's Disease (AD), the brain protein pathology in AD, and molecular-genetic studies of AD.

Four special sessions will include discussions of systemic manifestations, brain imaging, and legal, ethical, and social issues.

For registration information call Ralph W. Richter, MD, (918) 743-4374; Gary D. Miner, PhD, (918) 493-8476; or W. Daniel Cogan, EdD, (918) 493-8033. Mail requests should be directed to Dr Cogan, ORU School of Medicine — Continuing Education, 8181 South Lewis Avenue, Tulsa, OK 74137. Preregistration for the symposium is strongly encouraged. 

Death certificates (continued)

health departments are compiled at the national level," they say. In addition, many state health departments have broadened this reporting to include specific injuries and occupational illnesses.

Measures to improve the accuracy, timeliness, and completeness of vital statistics and disease reporting by physicians include education of medical students and house staff in postgraduate programs, incorporation of pertinent questions in medical and specialty board examinations, and training and feedback for practicing physicians, the researchers note. They add that professional societies also can help by educating members about the importance of vital registration and disease reporting. 

Screening in the workplace

Story examines defensibility of drug testing techniques

Urine drug testing methods vary widely in how well they can be legally defended, says a report in the *Journal of the American Medical Association*.

Employers testing workers for drug use should not count on single-procedure sampling if they want their cases to stand up in court, it concludes.

In designing a testing program, a company needs to ensure that initial positive results are confirmed by documented methods, warns the report, which is based on a survey of technical experts, labor arbitrators, and testing laboratories. It adds that such programs also need to ensure appropriate, documented administrative procedures and analytical controls, as well as see that the laboratory doing the work participates in a proficiency testing and inspection program.

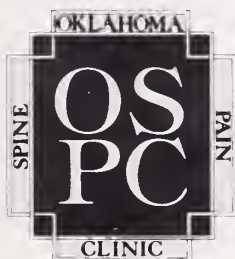
Employers are increasingly using urinalysis to detect workplace drug use; an estimated 40% of Fortune 500 companies implemented such programs in 1986. Yet while positive test results "can have a

significant effect on employees' lives and careers, and may face legal challenge," the report says, medical directors selecting testing laboratories have had few data relating analytical methods with legal defensibility — how well the methods would stand up to legal attack.

To obtain such data, the authors surveyed 25 urine drug testing experts, asking about the legal defensibility of different methods used. In addition, 300 labor arbitrators were questioned about their experience with drug testing cases.

The experts reported wide differences in the defensibility of different tests available, saying single-procedure methods "are not considered fully defensible against legal challenges. . . . Experts who must defend analytical data are of the opinion that retesting a sample that gives a positive result by a different procedure adds significantly to the defensibility of the data in court."

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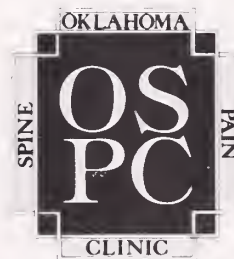
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Drug testing (continued)

The highest-rated single procedure test was gas chromatography/mass spectrometry (GC/MS), which is actually two procedures. GM/MS "is not commonly used as a single-procedure method because it is not best suited to the task of rapid screening in urinalysis," the authors say. However, it is considered the "gold standard" of confirmatory tests, and its use as such is consistent with established practices in law enforcement, horse racing, sports, military, and environmental pollutant testing programs, the report says.

Among the multiple-procedure methods, enzyme multiplied immunoassay technique (EMIT) and radioimmunoassay (RIA) were top-rated when GC/MS was used as the second, confirmatory test. If used alone — as in a screening procedure — EMIT and RIA each received the poorest overall defensibility ratings.

The arbitrators had considerable experience in drug use cases and understood the critical role of urinary analysis, the authors say. But "they were

unable to distinguish legal defensibility of analytical methods," the study adds, and "have little understanding of differences in accuracy among those commonly used."

The authors also note wide variation in commercial laboratory practice in urinalysis. Nearly a half-dozen different testing methods are currently used alone and in combination, the study says, and with the exception of the military, "no . . . consistent methodology or set of criteria has been established, thus far, for employee drug testing."

The survey found the cost of performing an initial test followed by GC/MS confirmation could be as low as \$20 per sample, as in the military's testing program, but that the price charged varies with the volume of specimens and number of substances to be analyzed. Laboratory and expert witness costs to defend test data against a typical challenge were estimated to be well in excess of \$1,000. Costs could be much lower if a well-documented chain of custody were available for the sample, and if methods were carried out using good forensic laboratory practices.



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State's clean indoor air law becomes effective November 1

Oklahoma's new clean indoor air law goes into effect November 1, and much of the credit goes to Otie Ann Carr, OSMA lobbyist, and Edward R. Munnell, MD, an Oklahoma City surgeon.

Dr Munnell is chairman of the Tri-Agency Coalition (American Lung Association of Oklahoma, American Heart Association, and American Cancer Society).

The legislation, signed by Governor Henry Bellmon on June 24, faced a strong lobbying effort from the tobacco industry. The final vote, however, was somewhat one-sided, with the Senate voting 40-4 and the House voting 64-18 for passage.

The law requires that public officials and owners or managers of designated private businesses establish smoking and no smoking areas. Public places affected include schools, auditoriums, arenas, theaters, museums, concert halls, health care facilities, governmental buildings, and restaurants that seat more than 50 people.

A 1981 law prohibits smoking in art galleries, museums, roller skating rinks, elevators, libraries, movie theaters, and buses.

Exempt from the new law are bars, restaurant lounges or bar areas, jails, prisons, and racetracks.



Specialty under pressure

Arizona doctor says there are too many pediatricians in US

Medical schools have produced an excess of pediatricians, according to a report in the *Journal of the American Medical Association*. Other pressures on the specialty include inadequate reimbursement for cognitive services, an increasing number of poor children, and professional liability associated with immunizations and the diagnostic process.

By the year 2000, we will have less than half the number of children per pediatrician that we had in 1970, says Vincent A. Fulginiti, MD, of the University of Arizona College of Medicine, Tucson, commenting editorially on a report from the Council on Long Range Planning and Development of the AMA. Fulginiti claims the report "does not lay out a strategy and set of tactics to get us to reach our goals, goals that should include reducing poverty, adjusting the number of pediatricians who will enter the profession, redistributing the excess number of pediatricians to underserved areas, and insisting on adequate compensation for ambulatory/cognitive services, which save patient costs and spare morbidity."

Fulginiti says that organized medicine must insist, through active government involvement, that poor children have access to medical care. In addition, changes and reductions in residency programs may be required to meet the needs of a shrinking patient population. Changes in reimbursement plans are long overdue, says Fulginiti: "We have tolerated for too long, and with much too passive an approach, the

disproportionate payment for catastrophic care and for procedure-oriented activity.

"Our agenda for seeking adequate compensation should have as its first priority the placing of cognitive care at a higher level, balanced by a reduction in the compensation for noncognitive care, to keep the total cost within bounds." Fulginiti encourages support of the Child Health Incentive Reform Plan, which demands that well-child care be included in the employer-based health care plans. The American Academy of Pediatrics is the major advocate of this program.



DEATHS

Dan Cross Galloway, MD 1943 - 1987

Dan Cross Galloway, MD, Oklahoma City neuro-radiologist, died July 12. The Electra, Tex, native earned his medical degree from the University of Oklahoma College of Medicine in 1969. He completed his internship and residency at the OU Health Sciences Center and served in the US Navy from 1974 to 1976. Dr Galloway was professor and vice chairman of the Radiological Sciences Department at OUHSC.

Oklahoma delegation reports AMA action at Chicago meeting

In May 1987, the House of Delegates of the Oklahoma State Medical Association (OSMA) passed a resolution requiring Oklahoma's AMA Delegation to publish in the JOURNAL of the OSMA a brief report on proceedings at AMA Annual and Interim Meetings. The following is a summary of actions taken by the AMA House of Delegates during the

Annual Meeting in Chicago last June:

AIDS was the dominant issue for the 406 delegates who attended the AMA Annual Meeting. The AMA House of Delegates approved Board of Trustees Report YY dealing with AIDS [see p 654]. Report YY states that education must be the major weapon to halt the spread of the HIV virus.

The report calls for mandatory HIV testing for donors of blood, blood fractions, organs, tissue, semen, ova, and all immigrants and US military personnel. Voluntary testing is encouraged for surgical patients requiring invasive procedures who live in areas with a high risk for AIDS or who engage in high-risk behavior.

Physicians may request a copy of Report YY by writing: AMA Council on Scientific Affairs, 535 North Dearborn Street, Chicago, Illinois 60610.

In other action, the AMA House of Delegates:

- Voted not to increase dues in 1988
- Rejected an AMA Board of Trustees recommendation to form a Section for Foreign Medical Graduates
- Adopted the following resolution regarding physician dispensing: "Resolved, the AMA supports the physician's right to dispense drugs and devices when it is in the best interest of the patient and consistent with AMA ethical guidelines."
- Continued opposition to DRGs for physicians
- Recommended the FAA ban smoking on all commercial flights
- Recommended 21 years as the legal age to purchase tobacco products
- Urged elimination of MAAC regulations
- Referred for study an Oklahoma resolution that would waive AMA dues for physicians elected to state or federal political offices
- Rejected an Oklahoma resolution that the AMA create a Council on Professional and Public Relations

The Oklahoma delegation spoke strongly against withdrawal of support for the World Health Organization, against expansion of the nursing profession into areas of medical practice, and in support of increased financing for rural health care providers. They also argued that foreign medical graduates should meet the same standards and pass the same tests as LCME graduates.

IN MEMORIAM

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1987

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Gladys Christine Smith, MD	May 27
John Ronald Watson, MD	June 14
Thomas Arthur Hosty, MD	June 17
Dan Cross Galloway, MD	July 12

A Vision Fulfilled: The Story of the Children's Hospital of Winnipeg, 1909-1973. By Harry Medovy. Winnipeg: Peguis Publishers Ltd., 1979. Pp 156, illus, price \$12.50.

This is the story of the Children's Hospital of Winnipeg, Manitoba, Canada, as seen through the eyes of Dr Harry Medovy. Dr Medovy has had a long association (50 years) with the institution. He began there as a resident and ultimately became professor and head of the Department of Pediatrics of the University of Manitoba School of Medicine and pediatrician-in-chief to the hospital. Although Dr Medovy does not give himself due credit for the progress, his indelible stamp on the hospital is apparent.

After some six years of intense work by a nurse, Mrs Bond, the hospital opened in a converted private home in 1909, and in 1911 it moved to a new building. From that point, five separate sections of the book describe the enormous progress and expansion that has occurred. Interwoven with this are profiles of members of the medical staff, many of whom are well known in the field of child health. The story is enhanced by some excellent photographs. The author is particularly sensitive to providing credit to the nonmedical supporters of the hospital over its years, who obviously have been an important and strong source of support. The hospital's nursing school is described in some detail.

The book is an interesting and engaging account of an important influence in Canadian child health. Among the important lessons it provides is the importance of the community in supporting a valuable resource.

*Harris D. Riley, Jr., MD
Oklahoma City*

Clinical Concepts of Infectious Diseases, 3rd edition. Edited by Leighton E. Cluff and Joseph E. Johnson, III. Baltimore: The Williams and Wilkins Co., 1982, pp 357.

This monograph is the third edition of this publication. A review of the second edition appeared in the *OSMA JOURNAL* 74:125, April 1981.

This edition represents an updated revision of the second plus additional new material. It contains a collection of essays emphasizing certain aspects of infectious diseases. There are 37 chapters contributed by 26 writers. The book is divided into five major

sections: "Epidemiology and Pathogenesis of Infectious Diseases," "General Problems of Infectious Diseases," "Specific Problems of Infectious Diseases," "Management and Prevention of Infectious Diseases," and "Tabulation and Other References of Infectious Diseases." The chapters on the phagocytic system, nonspecific resistance to infection, and humoral immunity have been revised substantially to incorporate new and current information. New chapters have been included also on the systemic mycoses, viral hepatitis, and antiviral chemotherapy.

The format follows that of the last edition.

In addition to chapters dealing with common infectious agents, there are certain chapters that do not usually appear in textbooks of infectious diseases — "Recovery from Infection" and "Abscesses" are examples that provide valuable information. The chapter "Tabulation of Infectious Diseases" and the chapter on selected references have been updated.

The volume focuses on clinical problems which the clinician is likely to encounter.

The final section again contains a useful tabulation of diseases by site, as well as a chapter of carefully selected references on various infections. This third edition is a very useful one and is recommended.

*Harris D. Riley, Jr., MD
Oklahoma City*

The Red River in Southwestern History. By Carl N. Tyson. Norman: University of Oklahoma Press, 1981. XVI, pp 222, illus, \$14.95.

This is the interesting account of an important river in the history of the American Southwest. The Red River has its headwaters from a thousand tiny rivulets in the foothills of the Rockies, crosses eastern New Mexico and the panhandle of Texas, becomes the border between Texas and Oklahoma, cuts across a corner of Arkansas, and proceeds southward through Louisiana until it empties into the Mississippi River in the central part of Louisiana, 300 miles from the Gulf of Mexico.

The author provides an engaging description of the river from its headwaters to its emptying into the Mississippi, a 1,200-mile course. He also provides interesting sketches of the various Indian tribes who resided along the river prior to the arrival of European populations in the 1500s.

The first Europeans to view the Red River were

members of the expedition led by Coronado into Texas in 1541. Separate chapters recount the extended disputes between the French and Spanish for control of the river during the 1600s and 1700s. This was followed by the periodic conflicts between Spain and the United States to define the border between Louisiana and Texas. Disagreements frequently developed as French traders in Louisiana and Spaniards in Texas competed for land along the Red River. The river was central to the final decision of the Adams-Onís Treaty of 1819 defining the western boundary of the Louisiana Purchase.

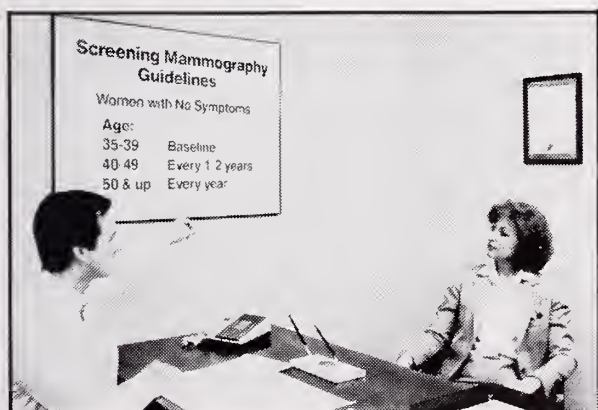
Considerable attention is devoted to the numerous attempts to remove or destroy the masses of driftwood interfering with navigation on the river and the military expedition led by Captain Randolph Marcy to trace the source of the river. During his expedition he also identified the Prairie Dog Town Fork of the river, which later became significant in the Greer County border dispute between Oklahoma

and Texas. Particularly interesting is a 30-page chapter dealing with the role of the Red River in the Civil War. The Confederates blocked the Union attempt to invade Texas by means of the river. This also prevented the invasion of northwest Louisiana.

Between 1930 and 1970, the United States Corps of Engineers constructed dams along the river to generate electricity, control floods, and create recreational lakes along the Texas-Oklahoma border.

The Red River has been the center of controversy from the beginning of the conflict between France and Spain in the Southwest to the end of the dispute between Oklahoma and Texas in the 1920s. This book will give the reader a better appreciation of the river and its role in the history of the Southwest. The book would be enhanced by a map showing the entire river.

*Harris D. Riley, Jr., MD
Oklahoma City*



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**News items for
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LIBRIUM® (N)

chlordiazepoxide HCl/Roche
5-mg, 10-mg, 25-mg capsules

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders; short-term relief of anxiety symptoms, acute alcohol withdrawal symptoms, preoperative apprehension and anxiety. Usually not required for anxiety or tension associated with stress of everyday life. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported after abrupt cessation of extended use of excessive doses are similar to those seen with barbiturates. Milder symptoms reported infrequently when continuous therapy is abruptly ended. Avoid abrupt discontinuation; gradually taper dosage.

Use in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. **Oral—Adults:** Mild and moderate anxiety disorders and symptoms, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. **Geriatric patients:** 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl/Roche) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in boxes of 4 reverse-numbered cards of 25, and in boxes containing 10 strips of 10. Libritabs® (chlordiazepoxide/Roche) Tablets, 5 mg and 10 mg—bottles of 100 and 500; 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.

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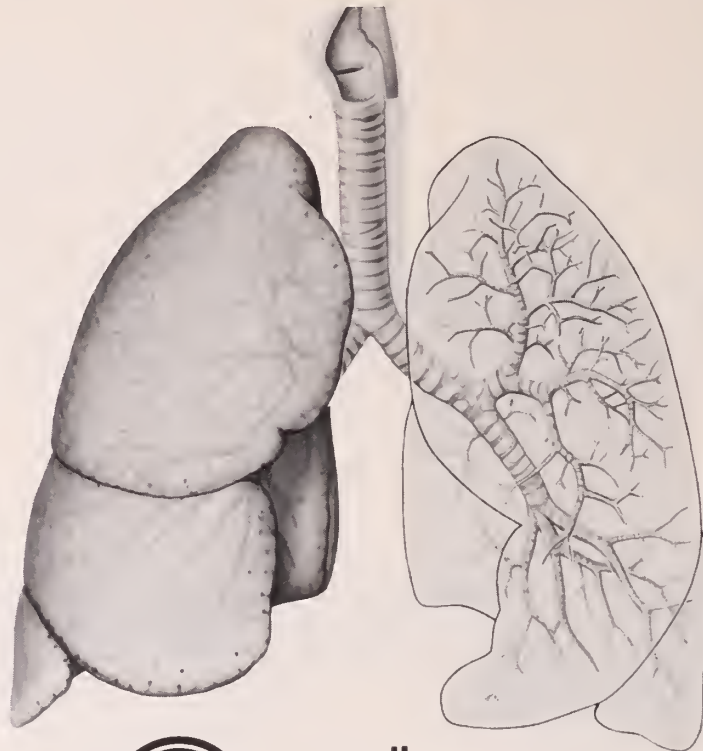


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Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor[®] (cefactor)

Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication:
Known allergy to cephalosporins.

Warnings:
CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients. Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness,

insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.

- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest[®] tablets but not with Tes-Tape[®] (glucose enzymatic test strip, Lilly).

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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to find
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Surprising? Not really.

Because most patients on INDERAL LA (propranolol HCl) don't even know it's working.

A recent double-blind, placebo-controlled, crossover study in 138 hypertensive patients² revealed that INDERAL LA has a side effects profile unsurpassed by atenolol or metoprolol — which shows how well-tolerated once-daily INDERAL LA can be.

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The patients in the nationwide compliance trial were no different from yours. Generally when the antihypertensive regimen is complicated, compliance may become a problem. So, the effectiveness of INDERAL LA as once-daily monotherapy is a big plus. Of the remaining hypertensives in the program, 36% were treated merely with the addition of a diuretic to INDERAL LA.

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Almost 20,000 of the patients in the nationwide compliance trial were identified as having been noncompliant with their previous antihypertensive therapy. Their physicians reported that 88% showed improved compliance when placed on once-daily INDERAL LA.

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INDERAL[®] LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA.

The one you know best keeps looking better

Please see next page for brief summary of prescribing information



The one you know best keeps looking better

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)

INDERAL® LA brand of propranolol hydrochloride (Long Acting Capsules)

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first-degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, after withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3 and decreasing T_3 .

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should

be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncope attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytin, phenobarbital, and rifampin accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and lidocaine have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS. INDERAL is excreted in human milk. Caution should be exercised when INDERAL (propranolol HCl) is administered to a nursing woman.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. Bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System. Light-headedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy, visual disturbances, hallucinations; vivid dreams, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy and vivid dreams appear dose related.

Gastrointestinal. Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic. Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory. Bronchospasm.

Hematologic. Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. **Auto-Immune.** In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. Alopecia, LE-like reactions, psoriasisform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION — Dosage must be individualized. The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS — Dosage must be individualized. Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE — Dosage must be individualized. The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS — 80-160 mg INDERAL LA once daily. **PEDIATRIC DOSAGE —** At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

REFERENCES:

- INDERAL LA National Compliance Evaluation Program. Data on file, Ayerst Laboratories.
- Ravid M, Lang R, Jutrin I: The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985, 145:1321-1323.

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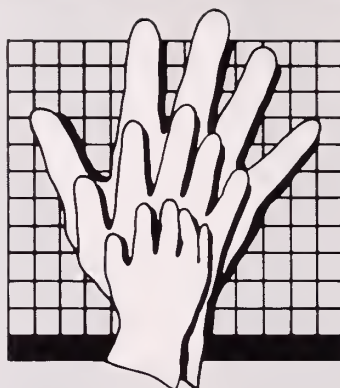
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Style

All manuscripts should adhere to the style adopted by the American Medical Association as illustrated in *JAMA* and detailed in the AMA's *Manual for Authors & Editors*. Footnotes, bibliographies, and legends for illustrations should be typewritten, double-spaced, on separate sheets. References are to be listed in the order of their appearance in the article.

Illustrations

Illustrations other than the author's will not be accepted for publication unless accompanied by written permission from the original source. Illustrations should be labeled with the author's name and must be numbered in the order in which they are referred to in the article. The quality of all illustrations must be in keeping with the quality of the magazine.

News

Readers are encouraged to submit news items of interest to Oklahoma physicians. Where dates of meetings, etc, are important, please remember that each issue closes on the first day of the *preceding* month and reaches subscribers in the latter half of the month of publication.

Reprints

Authors will receive reprint order forms from the Transcript Press, 222 East Eufaula, Norman, Oklahoma 73069, prior to publication of their articles. Other requests for reprints must be made to the Transcript Press within 30 days after publication.

Back Issues

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To Our Physician Partners . . .

Medicine is BIG news today . . . Each time you pick up your newspaper or turn on the TV, you read or hear about medical issues affecting the delivery of health care. Things have certainly changed from the time (not so very long ago) when the physician was in the driver's seat directing the health care of his or her patient without involvement from third-party payers, social agencies, and governmental regulations. Whether they wish to be or not, physicians are now surrounded by medical issues affecting their practice. Involvement of physicians is mandatory in the debate over health care issues if they wish to have influence in the future of medicine.

Although health care issues are drastically affecting the way that physicians practice medicine now, they will be even more of a factor in the future. By the year 2000, only 13 years away, more than 300,000 people will be over 85. The biggest segment of our population, the baby boomers, will be in their late 50s. Delivering, maintaining, and affording the quality health care to which we have become accustomed will be one of the greatest challenges that medicine will ever have.

What does that have to do with us now? NOW IS THE TIME that the groundwork is being laid for the health care delivery of the future. NOW IS THE TIME that teamwork in medicine will make a difference in that future. The Auxiliary has been in the past and is prepared to continue to be a dedicated and effective partner in the medical environmental challenges that lie ahead. Areas of special concern where Auxiliary can help are:

Legislation The national, state, and county auxiliaries have a phone bank network already in place which can be utilized when medical legislation is being determined in committees and *before* it is to be voted upon by legislators. The Auxiliary can work in the political campaigns of friends of medicine and help to educate legislators in medical issues. The joint efforts of the OSMA and the OSMAA in the successful MEDICINE DAY AT THE CAPITOL last February proves that working together can be more effective.

Health Education The Auxiliary will continue to promote health education through our national, state, and county health projects. As a result of the request of the AMA president to auxiliaries at Confluence II in Chicago last February, the OSMAA Health Project Committee has been working for

several months on an AIDS Education project to disseminate current and correct information to our county auxiliaries and members-at-large so that they may be a force in educating their communities.

Malpractice Threat Some county auxiliaries already have malpractice support groups functioning to help medical families stricken by this ever-increasing problem. The OSMA Auxiliary is offering a malpractice support group workshop at our Fall Confluence this month. It is also our desire to work with our physician partners to expand this important support area.

Public Image The media coverage of lawsuits and sky-rocketing medical costs has given medicine a black eye, in general, and physicians, in particular. Auxiliaries working within the community toward a better medical environment will give the public additional proof that physicians care. Whether bargained for or not, auxiliaries represent their physician spouses in public. Simply being married to a doctor places the spouse in the public eye. Conclusions are drawn from lifestyles made available through care of the sick. If auxiliaries seem unconcerned about those less fortunate, the stigma will attach to the physician as well. This is a heavy responsibility and one which auxiliaries handle well through state and county auxiliary projects as well as individual efforts in their communities.

Stress Management Stress from the changing medical environment not only affects the physician but also the physician's family. The Auxiliary will address different areas of stress in the medical marriage at our annual Fall Confluence this month, September 28-29, at the Waterford Hotel in Oklahoma City. It will be a valuable, educational experience for your spouse and will merit your encouragement of his or her attendance.

We need your spouse's involvement in Auxiliary so that we can be even more effective in our efforts to work with you to attain a healthier and happier medical environment. *Please help by asking your spouse to become a member of the county auxiliary or a member-at-large if there is not an organized county auxiliary in your area.* Together we CAN make a positive difference in our medical future.

—Julie Weedn
OSMAA President

THE LAST WORD

■ **The Oklahoma chapter of the American Academy of Family Physicians (AAFP)** finished in a first-place tie with Louisiana for 1986 member recruiting activities. The award for having the highest percentage of resident members was accepted by **Ronal D. Legako, MD**, Edmond, at the AAFP's State Officers Conference in May.

■ **July 28 was Claude B. Knight Day in Wewoka**, as the community honored the family practitioner. Dr Knight, a 1935 graduate of the University of Oklahoma College of Medicine, celebrated 50 years of practice on August 1.

■ **OSMA Executive Director David Bickham** was recently elected to a two-year term on the Board of Directors of AAMSE, the American Association of Medical Society Executives. The election was held July 31 in New Orleans at AAMSE's annual meeting.

■ **The Tulsa County Medical Society (TCMS)** has received an unprecedented second award for service to older Tulsans from the Tulsa Coalition for Older People (TCOP). The award comes as a direct result of Very Important Patient (VIP) program and was presented to TCMS Past President **Rollie E. Rhodes, Jr., MD**, who helped launch the program.

■ **Tulsa County Medical Society President Jerry L. Puls, MD**, has named pathologist **Sandra K. Dimmit, MD**, as chairman of the TCMS Women Physicians Task Force. The task force was established to address areas of specific interest to the more than 80 women physician members of TCMS.

■ **Elderly patients hospitalized with broken hips** may not get the rehabilitative care they need under the diagnosis related group (DRG) system for Medicare reimbursement, says a report in the *Journal of the American Medical Association*. John F. Fitzgerald, MD, of the Indiana University School

of Medicine, Indianapolis, and colleagues studied 282 such patients hospitalized between 1981 and 1985. After DRGs went into effect, mean length of hospital stay fell from 16.6 to 10.3 days, and mean number of physical therapy sessions received fell by half, the authors say. At the same time, the proportion of patients discharged to nursing homes more than doubled. "These results reflect a disturbing pattern of deteriorating care provided to these Medicare recipients since the introduction of (DRGs) and suggest a potential overall cost increase," the study concludes.

■ **Joe D. Haines, Jr., MD**, medical director of the Skiatook Family Medicine Center, was recently named to the editorial board of *Postgraduate Medicine*. Dr Haines, a family practitioner, has published more than 20 articles in the last two years and is a frequent contributor to the OSMA JOURNAL.

■ **C. Scott Williams, MD**, an allergy specialist, conducted a Family Asthma Workshop at the Jane Phillips Episcopal-Memorial Medical Center in Bartlesville on May 16. Dr Williams is a 1967 graduate of the University of Oklahoma College of Medicine.

■ **Oklahoma City endocrinologist Curtis E. Harris, MD**, has been named president-elect of the American Diabetes Association, Oklahoma affiliate. He was also recently named president of the American Academy of Medical Ethics. An associate clinical professor at the University of Oklahoma Health Sciences Center, the Oklahoma native was graduated from the University of Washington School of Medicine, Seattle, in 1973.

■ **James R. Taylor, MD**, a general practitioner in Bartlesville, is currently serving on the Board of Directors of Flying Physicians Association, Inc. Dr Taylor was elected to the board in 1985. □

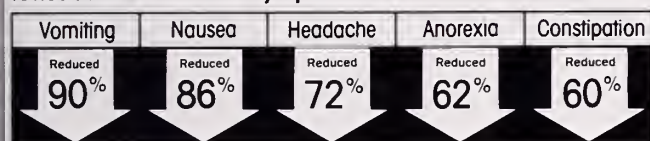
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety. **Contraindications:** Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors. Severe hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then rare cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of QT interval have been reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Use in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those associated with withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of additive effects in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported (delayed elimination and increasing steady state concentrations of the tricyclic drugs).

Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated. Sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to initial treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to lowest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone.

Common reactions: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.

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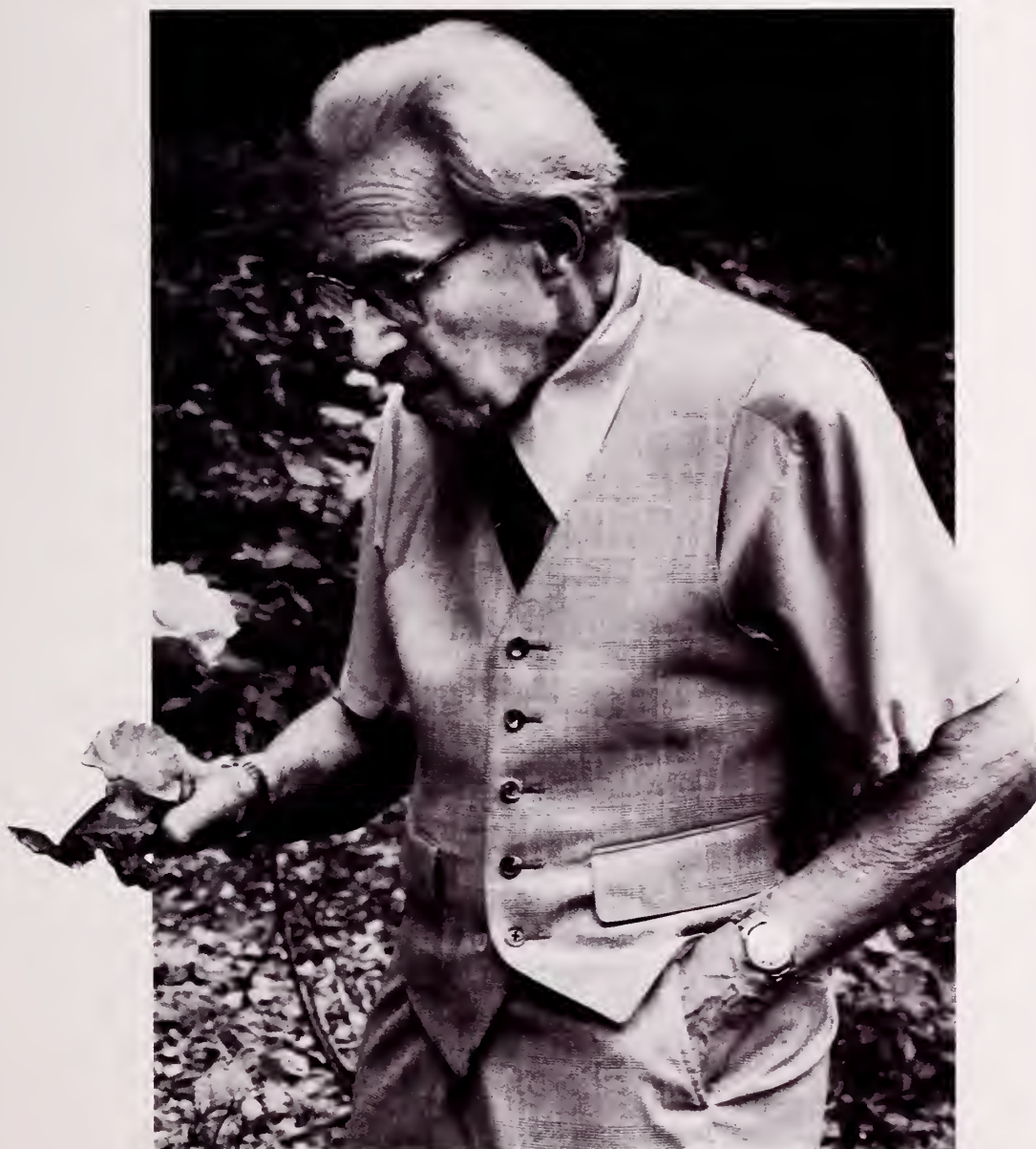
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CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension. It may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first-degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T₄ and reverse T₃ and decreasing T₃.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL. Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should

be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenyltol, phenobarbital, and rifampin accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and lidocaine have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T₃ concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS. INDERAL is excreted in human milk. Caution should be exercised when INDERAL (propranolol HCl) is administered to a nursing woman.

PEDIATRIC USE. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. Bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System. Light-headedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy, visual disturbances, hallucinations, vivid dreams, an acute reversible syndrome characterized by

disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy and vivid dreams appear dose related.

Gastrointestinal. Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic. Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory. Bronchospasm.

Hematologic. Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-immune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. Alopecia. LE-like reactions, psoriasisform rashes, dry eyes, male impotence and Peyronie's disease have been reported rarely. Oculocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION — Dosage must be individualized. The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 64 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS — Dosage must be individualized. Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value of safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE — Dosage must be individualized. The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS — 80-160 mg INDERAL LA once daily. **PEDIATRIC DOSAGE —** At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

REFERENCES:

1. INDERAL LA National Compliance Evaluation Program. Data on file, Ayerst Laboratories.
2. Ravid M, Lang R, Jutrin I. The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985; 145:1321-1323.

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JOURNAL

OKLAHOMA STATE MEDICAL ASSOCIATION

OCTOBER 1987

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CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.

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Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS:

Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.

Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.

Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Use in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.

Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.

Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression: (See WARNINGS.)

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.

The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982.

5685

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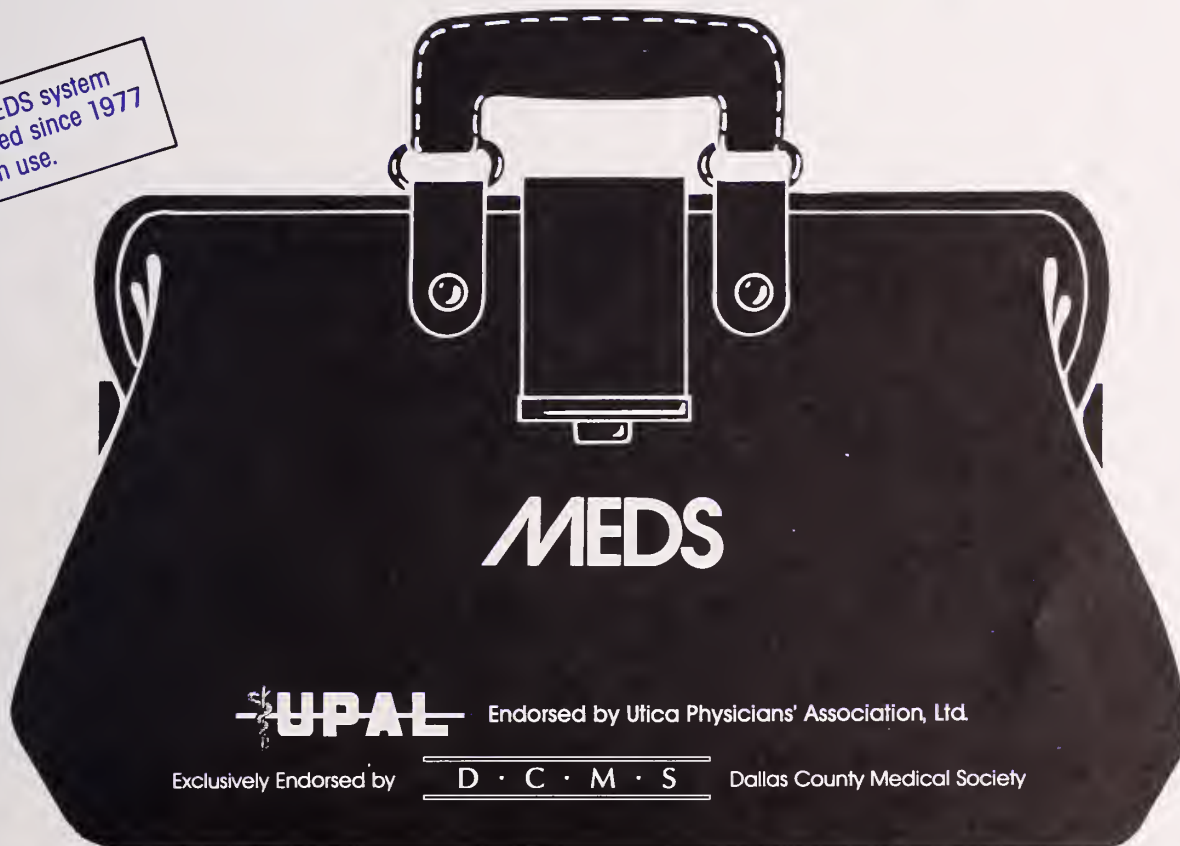
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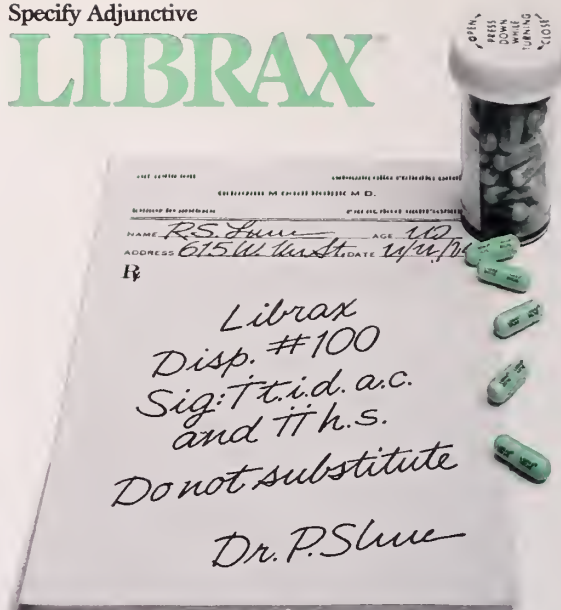
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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur. **Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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Taint Funny

You've seen the bumper sticker that says, "Support Your Local Attorney; Practice Medicine." It probably caused you to smile or smirk as you perceived a humorous exaggeration of the medical malpractice situation.

If you keep up with the national medical news, you must agree that it is time to contemporize the wording on the sticker. It should say, "Support the Legal Profession; Practice Medicine."

Headlines which caption stories concerning hospitals, physicians, and the practice of medicine could, almost half the time, as appropriately caption stories concerning courts, lawyers, and the practice of law. The stories themselves detail the results of court decisions in three-to-five-year legal battles, the opinions of legal experts, the decisions of attorneys general, the advice of legal counsels, the interpretations of judges, the accusations of lawyers, and the pronouncements of elected and appointed officials who also happen to be lawyers.

Today, it is not unusual that a trial involving a single physician will employ three or four lawyers and one or more judges for two or three years.

It is probably not rare that a judicial proceeding involving the practice of medicine is concluded without hearing an utterance from a single practicing physician. It is traditional that when medical experts are sought by the bureaucrats, their selections are usually young, full-time academicians who have spent less than two years in the private

practice of medicine. Frequently such endowed authorities haven't spent a single day in private practice.

Recently, an article in a medical newspaper indicated that the millennium has arrived for those of us who do practice medicine. A legal expert warned us against quietly submitting to the decisions of utilization review committees, peer review organizations, and insurance company surveyors. It is our proper duty and responsibility, he proclaimed, to protest; to scream, to complain, to call for special meetings, to fight in defense of our own opinions; to ensure that our best professional judgment prevails.

Of course, since we face banks of lawyers retained to challenge our opinions and refute our judgment, it can follow that our proper duty is to hire other lawyers to defend them.

The situation is so bad it is likely that, in a few years, more lawyers than physicians will be employed in the health care professions. In view of this reality and the evidence supporting it, perhaps it is time to change the academic requirements for admission to medical school. A law degree should be mandatory.

At the very least, the new bumper stickers should say, "Support the Legal Profession; *TRY* to Practice Medicine."

It's no longer exaggerated. And, it's no longer funny.

—MRJ

Very Important Patients

Sometimes you do have to give the government credit. It probably wasn't intended but the Congress has so successfully ruined the Medicare program that natural allies — doctors and their patients of long standing — have become enemies.



Our Medicare patients are angry because they pay more out of pocket for health care than before Medicare started. Physicians chafe under ponderous rules and regulations written by bureaucrats with no understanding or concern for the realities of the practice of medicine and the needs of our patients.

Dissatisfaction with the system somehow has driven Medicare patients and their physicians apart rather than bringing them together.

If doctors and patients can't work together to ensure an excellent future for our health care system, then God help us all.

This is an absurd situation which must not continue.

We must reopen lines of communication and listen to what our Medicare patients are saying.

The appointment of an OSMA Senior Citizen Advisory Committee is a first step in this effort.

The committee's first major project will be the statewide implementation of Tulsa County Medical Society's VIP (Very Important Patient) project.

Simply, VIP physicians agree to accept assignment for patients certified eligible for the VIP program. Aetna Medicare reports that 60% of all Part B Claims in Oklahoma are assigned.

Participation in the VIP program will clearly indicate that Oklahoma physicians want to do their part to assist our older patients.

All county societies have been contacted about VIP. If your society has not made a decision on VIP, I urge you to do so as soon as possible.

Please have a representative from your county contact OSMA headquarters for information and assistance in implementing VIP in your community.

Don't delay in sending this very important message that we sincerely care to our Medicare patients.

W. J. Crosthwaite, M.D.

Whichorexia: A Disorder of Inaccurate Name, Uncertain Heterogeneity, Questionable Etiology, Variable Course, and Uncertain Outcome

JAMES R. ALLEN, MD

Anorexia nervosa is a baffling disorder. It primarily affects intelligent young women who show a near delusional insistence that they look just right, an intense fear of becoming fat, willful starvation, a perfectionistic attitude, and an obsessional concern with food and cooking. It has inspired a large number of publications, but little consensus. A century after Gull described the condition, it still is a disorder of uncertain heterogeneity, questionable etiology, variable course, and uncertain outcome.

The clinical syndrome we classify as anorexia nervosa continues to be a mysterious condition. It is a disorder which affects apparently previously healthy teenagers and young people and leads to self-starvation that may become life threatening. Yet, the very diagnosis is a misnomer, for these young people are typically not anorectic at all, but obsessed with thoughts of food and an avid desire to eat. Most insist their emaciated bodies are grotesquely overfleshed, their shrunken abdomens "just right."

Research on the condition has been hampered by numerous methodological problems. Many of the conclusions are drawn from atypical samples. Few data exist on the percentage of people with this condition who refuse treatment — 30% in Crisp's report¹ — and their eventual outcome.

The diagnostic criteria listed in the *Third Diagnostic and Statistical Manual (DSM III-R)* of the American Psychiatric Association are:

- Refusal to maintain normal body weight
- Loss of more than 15% of original body weight
- Intense fear of becoming fat
- No known medical illness leading to weight loss
- Disturbance in the way one's body is experienced

These criteria are not without problems. The distinction between a bulimic subgroup of anorexia nervosa and bulimia nervosa is blurred. Indeed, variations in age of onset, duration, and the presence of depressive and bulimic features all suggest heterogeneity within the syndrome — a hypothesis supported by findings that more severely depressed groups show lower levels of plasma cyclic-AMP and MAO activity.² Currently, the practice is to distinguish these subgroups by body weight: if a bulimic patient is emaciated, she is categorized as anorexia nervosa, bulimic subgroup; if she is of normal weight, she is classified as bulimia nervosa. As compared with restrictive anorexics, bulimic anorexics tend to be older, less socially isolated, show more evidence of premorbid social instability, and have a higher incidence of familial obesity. Most workers have long emphasized that anorexics have distorted images of themselves; however, a few have reported no

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differences in this area between anorexics and people of normal body weight.

Although *DSM III-R* makes no such distinction, several authors recognize primary, secondary, and atypical types of anorexia nervosa, although there is considerable variation in their respective definitions.

Etiology

While anorexia nervosa may have a single discrete cause, it seems more likely that it is a result of a multifactorial chain of events. In this context, the concept of a "cause" is really only a convenient designation for some point in a chain of interdependent events, a point which draws our attention, or where intervention is most practicable or effective.

Currently, there are six main groups of hypotheses as to the etiology of anorexia nervosa. Organized around differing conceptual levels, they are not mutually exclusive, although their main emphases are distinct.

Primary Hypothalamic Dysfunction. The facts that amenorrhea frequently occurs before any appreciable weight loss, and that there is continuing amenorrhea and hypothalamic underfunctioning after weight gain suggest some type of hypothalamic disorder.³ Indeed, amenorrhea seems to precede the onset of any weight loss at all in 7% to 25% of cases,⁴ although these figures may be suspect because of the difficulties inherent in gathering accurate retrospective data from this population.

Affective Disorders. Cantwell et al⁵ have produced evidence to suggest that anorexia nervosa may be some form of atypical affective disorder. However, most follow-up studies suggest that anorexia nervosa "breeds true."⁶ Yet, there is an increase in affective disorders in these families, and anorexics are more likely to develop an affective disorder than to suffer a relapse of the eating disorder later in life.

Developmental Avoidance. Crisp⁷ has repeatedly suggested that this disorder is rooted in a phobic avoidance of adult weight and, more particularly, in the young person's need to avoid the psychological and biological consequences of adolescence. Indirect support for this hypothesis can be found in the clinical observation that many anorectics will agree to eat provided they do not gain weight, and the fact that the emotional status of their parents often worsens when the patient recovers.⁸ However, this hypothesis has never been tested empirically.

Individual Psychodynamics. Hilde Bruch,

attempting to bring some order to psychoanalytic thinking on anorexia, has suggested that a struggle for a self-respecting identity lies at the core of this disorder,⁹ and this finding has now been reported by many others. Indeed, many of these patients seem closely related to the narcissistic personality disorders in their psychodynamics. That their struggle needs to take the form of willful starvation suggests serious psychological developmental deficits — such as a failure of the parents to regard the patient as an individual in her own right and to transmit to her a sense of self-value and competence. Because of their lack of autonomy and a paralyzing sense of ineffectiveness, these patients come to interpret thinness as specialness and self-control. While very plausible, these hypotheses have not been tested empirically.

Family Pathology. Since the early reports of Charcot, Gull, and Laseque, clinicians have emphasized the family pathology of these patients. In the past decade, several groups have described what they consider typical interactional pathologies of the families. The characteristics most frequently identified are: enmeshment, overprotectiveness, rigidity, and lack of conflict resolution. The child who

The incidence of anorexia nervosa seems to have doubled over the past 20 years.

becomes anorectic maintains family stability and is triangulated in covert conflict which underlies the parental facade of happiness and stability. However, it remains to be demonstrated that specific abnormal family interactional patterns occur in anorexia nervosa, or that they are related to the development of the condition.^{10,11}

Genetic factors also seem important. Monozygotic twins have a concordance rate of about 50%,¹² but adoptive studies are needed to distinguish genetic from environmental factors. Indeed, Crisp and Toms¹³ have described a case of a chronic male anorectic whose adoptive son and a girl who stayed with the family both developed anorexia nervosa.

Social-Cultural Influences. Anorexia

nervosa occurs more commonly in females than in males and seems to affect predominantly upper-class girls in developed countries. The pressure on women, especially those of the upper classes, to be thin is considerable and may precipitate this method of striving for perfection and control. Pumanesa,¹⁴ studying a nonclinical group of Hispanic girls in cultural transition, found that greater adherence to the norm of our prevalent US culture increased the individual's vulnerability to the development of an eating disorder. However, it is obvious that not all women exposed to such pressure develop anorexia nervosa.

In view of our current state of information, it would seem best to regard anorexia nervosa as a heterogeneous condition that may arise from various combinations of these — and presumably other — etiologic factors. That is, it is a final common pathway.

Epidemiology

The prevalence of the disorder appears to be increasing. Using strict diagnostic criteria, Crisp¹⁵ found severe anorexia nervosa in 1% of British students aged 16 to 18 years. Approximately 90% of that 1% are females. The boys who develop the condition tend to be more schizoid and paranoid, not uniformly good students as are the girls, and tend to be more resistant to treatment.¹⁶

The incidence of anorexia nervosa seems to have doubled over the past 20 years. A retrospective study in Monroe County, New York, found the incidence increased from a rate of 0.35 per 100,000 from 1900-1969 to 0.64 per 100,000 from 1970-1976.¹⁷ A Swiss study found that from 1950 to 1970, the incidence rose from 0.38 to 1.12 per 100,000.¹⁸ However, it is unclear whether these figures are more indicative of true incidence or of increased awareness of the condition.

Natural History

Anorexia nervosa usually occurs between age 12 and the mid-thirties, with a bimodal age of onset: 13-14 years and 17-18 years. Long-term studies indicate that after five years, only 35% of these patients are eating normally and are free of obsessions about body weight,^{19,20} although about 75% eventually find full-time employment and improve in terms of weight, menses, and social adjustment. Mortality rates vary from 3.6% to 6.6%, although some report rates up to 25%.²¹ Relapse occurs within a year in about 50% of patients "successfully" treated in

hospital settings. Suicide has been reported in 2% to 5%.

Starvation itself produces a number of physical and psychological effects which give these patients a common presentation. The physical effects include dry skin, lanugo hair, hypothermia, syncope, hypotension, hypoglycemia, hair loss, sensitivity to noise, fatigue, leukopenia, electrolyte abnormalities, amenorrhea, and superior mesenteric artery syndrome. The accompanying psychological disturbances include poor concentration, depression, labile mood, and preoccupation with food.

The following factors have been reported to suggest a favorable prognosis:²²

- Early age of onset
- Hysterical personality structure
- Short duration of symptoms
- Diminution of disturbances of body perception following weight increase

The following are associated with a more unfavorable prognosis:

- Vomiting
- Abuse of purgatives
- Bulimia
- Compulsive personality traits
- Numerous physical complaints
- Psychological test results suggestive of psychosis

Some patients with anorexia nervosa engage in binge-vomiting. Casper²³ reported this behavior in 47% of his patients, and Garfinkel et al²⁴ in 48%. According to Garfinkel, this subgroup shows a wide variety of impulsive behaviors.

The varying types of psychiatric diagnoses that have been reported as associated with anorexia nervosa make it difficult to draw firm conclusions about associated psychopathology. Obsessive-compulsive traits and depression are frequently found. Psychotic disorders occur in fewer than 10% of cases and appear best understood as a separate and second condition. Narcissistic and borderline features are frequent. The older idea that anorexia nervosa is, in some cases, a form of schizophrenia has been dropped.

Body-image and perceptual disturbances have been identified in many anorexics. However, it is not clear whether a distortion in body image leads to initial weight loss or whether initial weight loss, for whatever reason, leads to the distorted perception.

Treatment

Patients with this disorder are treated with a wide range of treatment methods. This is due in part to the variety of different views on the nature of the disorder and in part to the lack of consistently good results afforded by any one treatment. Usually a combination of treatments is undertaken, making it difficult to identify which elements are effective.

Clinicians treating these patients need to use a truly biopsychosocial approach, for they have to manage the medical complications of starvation as well as the interpersonal stresses and the intrapsychic problems of their patients. Whether he uses individual, group, or family methods, psychodynamic or behavioral approaches, however, the physician usually faces a long-term process. In the absence of controlled studies, the relative merits of each approach cannot adequately be evaluated. Countertransference difficulties are likely to develop as a result of the patient's silences, refusal to eat, dishonesty in regards to food, and interpersonal behaviors. Anorectic patients and their families tend to deny the illness, especially its severity, and to avoid adequate care.

Treatment Setting

Many of these patients do not come for treatment until they have lost considerable weight. The signs and symptoms of starvation usually require hospitalization when weight loss reaches 25%. Such a hospitalization may include nasogastric tube feedings, hyperalimentation, behavior modification, and pharmacotherapy, including chlorpromazine and antidepressants as well as the use of some more experimental drugs such as cyproheptadine. Without strong psychotherapeutic support, however, many of these patients will not tolerate weight gain.²⁵

Inpatient treatment may be lifesaving for the emaciated patient. Although the short-term benefits seem indisputable, long-term effectiveness is still doubtful. There is also no consensus on criteria to judge when an inpatient is ready for discharge — restoration to matched-population mean weight, low average weight, age-appropriate weight — or some other criterion.

With weight gain, the superficial similarities between patients occasioned by weight loss and starvation tend to disappear. Differences between them begin to emerge and require different therapeutic approaches. This may take the form of individual, group, or family treatment or, more likely, some combination of the above.

Family Therapy

Minuchin¹⁰ and Palazolli-Selvini¹¹ use family therapy as the principal mode of treatment in this condition, believing that the anorexic's behavior is an interpersonal or systemic problem rather than an individual one and that the treatment therefore should be directed toward restructuring the family system. Using the emotionally charged mealtime situation, Minuchin reports high success (86%) in restructuring family patterns of enmeshment, rigidity, and poor conflict resolution. Palazolli and her Milan associates have developed a whole new type of therapy, systemic family therapy, involving prescribing the system, the use of counterparadox, and ritual.

Unfortunately, these authors ignore the heterogeneity of the syndrome, and their follow-up evaluations have been criticized for lack of rigor.

Cognitive-Behavioral Therapies

Because of its potential for rapid weight gain, behavior modification is frequently employed with these patients, although there has been considerable criticism of these approaches because of their potentially coercive nature — especially if the patient's major underlying problems center around the issue of autonomous behavior, and because of the

**Relapse rates
and outcomes
are very similar,
whatever the treatment.**

ethical and legal dilemmas occasioned by enforced treatment. Nevertheless, operant reinforcement, relaxation techniques, systemic desensitization, and the practicing of avoided behaviors are commonly employed.

A major problem even with many behavioral studies, however, has been the failure to conduct adequate follow-up. Touyz et al²⁶ found no differences in mean weekly weight gain between patients in a strict behavioral program and those in a more lenient one. Eckert et al²⁷ found no significant difference in weight gain after 35 days between patients randomly assigned to either behavior modification or milieu therapy. One of the most comprehensive follow-up studies concludes: "Operant conditioning techniques

are often inadequate for long-term maintenance of normal eating habits. . . . These methods are probably best used simply as a means of rapid weight restoration."²⁸

Anorectic patients generally have several distorted ideas which seem to predispose and maintain their behavior: One should strive for perfection; weight gain means one is out of control or bad; fat is disgusting and thinness admirable; and asceticism is superior to self-indulgence. These are the subjects of the cognitive therapist's attention.

Psychodynamic Approaches

For most clinicians, individual psychotherapy remains the cornerstone of treatment. Until recently, classical psychoanalytically oriented psychotherapy was judged highly ineffective for this group of patients. However, advances in the last decade in the areas of object-relations theory, the processes of separation individuation, and the development of a coherent and rigorous sense of self have modified this picture.²⁹⁻³¹

It is now apparent that the syndrome of anorexia nervosa can be embedded in a variety of personality organizations and defenses. Aversion to sexuality, a pathological sense of self related to disturbances in mirroring during the separation-individuation stage of development, body-image distortion, an incapacitating sense of ineffectiveness, weight phobias, and depression are typical psychodynamic issues that the therapist needs to address.

Pharmacotherapy

A number of medications have been used either to induce weight gain or to correct some hypothesized central neurotransmitter dysfunction, and there is some evidence that certain psychotropics are useful in the short term, when used in conjunction with behavior or milieu therapy. Antidepressants, for example, have been reported effective in inducing weight gain in several open trials, and amitriptyline has been found superior to placebo.³² Lithium carbonate has also been reported superior to placebo in an eight-week trial.³³

From their analysis of 45 follow-up studies in English and German published between 1953 and 1981, Steinhausen and Glanville²² agreed with several authors that, at present, there is good evidence for neither a specifically effective form of treatment for the disorder nor for any qualitative differences between therapeutic regimens. Others have attempted to prove the effectiveness of their

particular methods of treatment by referring to their follow-up results. However, these reports generally need to be viewed with a very critical eye. Most involve too few subjects, too short a follow-up period (less than four years), too few criteria for evaluation of outcome, failure to report the proportion of drop-outs (which may be as high as 77%), or failure to perform direct re-examination at follow-up, relying instead on telephone calls or indirect questions of relatives and friends.

In their recent follow-up study of recovered anorexics, Clinton and McKinley³⁴ found that the distorted beliefs and attitudes connected with food remain largely unaltered by current treatment methods. There seems to be a lack of synchrony between the gross physical and behavioral symptoms and the cognitive correlates of the disorder; yet, it is not known whether these distorted beliefs and attitudes slow down treatment. The most important question remaining is how these distorted attitudes toward weight, eating, and food can be more effectively treated.

In reality, in the absence of good data on treatment effectiveness, most patients today receive a grab-bag of group therapy (behavioral, psycho-educational, dynamic, or self-help) which at least allows them to feel less alone, to get feedback, and to enhance social skills; family therapy (structural, systemic, strategic, psychodynamic, or psycho-educational) which at least helps family members feel more connected and facilitates communication; and cognitive-behavior therapy to help alter unhealthy eating and distorted thinking patterns. At this stage in our knowledge, it would appear that relapse rates and outcomes are very similar, whatever the treatment.³⁵ It is apparent, however, that whatever the outcome in terms of weight gain and restoration of menses, these patients are likely to need continuing support for the distressing symptoms of depression, loneliness, obsession with weight, and social isolation.

A century after its description by Gull, and after hundreds of publications, anorexia nervosa remains a disorder of inaccurate name, uncertain heterogeneity, questionable etiology, variable course, and uncertain outcome.

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Coming in November . . .

Among the manuscripts being considered for publication next month are a report on lithotripsy in Oklahoma and an overview of brachial plexus injuries.

A commentary on AIDS and nuclear war is also scheduled.

Anatomy Quiz: Longest, Largest, Strongest, Principal, Most, and Only

JAMES R. GEYER, MD

This anatomy quiz calls attention to structures, actions, and conditions that are described in the standard textbooks as the longest, largest, strongest, principal, most (most important, most common, most movable, etc), or only one of a kind.

Muscles

1. Only muscle innervated by the glossopharyngeal nerve
2. Only external muscle of the larynx, and only muscle innervated by the superior laryngeal nerve
3. Only muscle that abducts the vocal cords
4. Principal and most important muscle of respiration
5. Thickest and most fleshy portions of diaphragm
6. Only muscles that are supplied by dorsal rami of spinal nerves
7. Largest muscular mass of the back
8. Broadest muscle of the back
9. Most powerful flexor of the thigh, and one of the largest and most powerful muscles in the body
10. Longest muscle
11. Only muscle that can actively extend at the knee joint

12. Most superficial muscle of the calf
13. Only good functional plantar flexor at the talocrural joint
14. Strongest tendon
15. Strongest dorsiflexor and invertor of the foot

Nerves

1. Only branch of trigeminal nerve that contains voluntary motor fibers
2. Largest branch of lumbar plexus
3. Largest plexus of somatic nerves
4. Principal nerve of the perineum
5. Largest nerve, a nerve that is really two separate nerves that are united only by a common sheath of connective tissue
6. Principal nerve of the anterior muscles of the thigh
7. Principal nerve of the medial muscles of the thigh
8. Principal nerve of the posterior muscles of the thigh
9. Principal nerve of the anterior compartment of the leg
10. Principal nerve of the lateral compartment of the leg
11. Principal nerve of the posterior compartment of the leg

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Bones, ligaments, and joints

1. Most frequently fractured bones in the head
2. Only synovial joints in the head
3. Only bony articulation between the upper extremity and the axial skeleton
4. Most movable joint, and joint most prone to dislocation
5. Most frequently fractured carpal bone
6. Largest bones
7. Strongest ligament
8. Largest and most important ligament of hip joint
9. Largest sesamoid bone
10. Only external ligament of knee joint that is not intimately blended with the articular capsule
11. Meniscus in knee that is most frequently torn
12. Most common sprain of any joint
13. Only motions at ankle joint
14. Largest and strongest bone of the foot
15. Most common abnormalities of foot

Vessels

1. Largest of the arteries to the covering of the brain
2. Only constant tributary of the subclavian vein
3. Largest lymphatic
4. Largest (widest) vein
5. Longest vein
6. Two largest branches of the profunda femoris artery
7. Most deeply (anteriorly) placed structure in the popliteal fossa

Other

1. Only paranasal sinus with gravity drainage in the erect posture
2. Largest endocrine gland
3. Largest serous sac
4. Largest and most vascular organ
5. Largest lymphoid mass
6. Only direct communication into the peritoneal cavity from the exterior

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Answers**Muscles**

- | | |
|-----------------------------|--|
| 1. stylopharyngeus | 9. iliopsoas |
| 2. cricothyroid | 10. sartorius |
| 3. posterior cricoarytenoid | 11. quadriceps femoris |
| 4. diaphragm | 12. gastrocnemius |
| 5. crura | 13. triceps surae (gastrocnemius and soleus) |
| 6. deep muscles of the back | 14. tendo calcaneus (Achilles) |
| 7. erector spinae | 15. tibialis anterior |
| 8. latissimus dorsi | |

Nerves

- | | |
|------------------|--------------------------|
| 1. mandibular | 7. obturator |
| 2. femoral | 8. tibial |
| 3. sacral plexus | 9. deep peroneal |
| 4. pudendal | 10. superficial peroneal |
| 5. sciatic | 11. tibial |
| 6. femoral | |

Bones, ligaments, and joints

- | | |
|---|---|
| 1. (1) nasal and (2) mandible | 8. iliofemoral |
| 2. temporomandibular joint and joints of ossicles of middle ear | 9. patella |
| 3. sternoclavicular articulation | 10. fibular (lateral) collateral ligament |
| 4. glenohumeral (shoulder) | 11. medial meniscus |
| 5. scaphoid | 12. sprain of ankle |
| 6. (1) femur and (2) tibia | 13. dorsiflexion and plantar flexion |
| 7. iliofemoral (the "Y" ligament of Bigelow) | 14. calcaneus |
| | 15. (1) flatfoot and (2) clubfoot |

Vessels

- | | |
|----------------------------|---|
| 1. middle meningeal artery | 5. great saphenous vein |
| 2. external jugular vein | 6. medial and lateral femoral circumflex arteries |
| 3. thoracic duct | 7. popliteal artery |
| 4. inferior vena cava | |

Other

- | | |
|------------------|-------------------------|
| 1. frontal sinus | 4. liver |
| 2. thyroid | 5. spleen |
| 3. peritoneum | 6. female genital tract |

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Leaders in Medicine Leo Lowbeer, MD

Story by Richard Green
Photographs by J. Don Cook

. . . Those born at the beginning of the century in Vienna must have taken for granted that this charming civilized world would go on forever . . .

— William L. Shirer

In 1901, Leo Low-beer was born in Vienna in the shadow of the Alps and at the pinnacle of European civilization. Though art of all kinds flourished in Vienna, music was the greatest. There beneath the inspirational Vienna woods, Haydn, Mozart, Beethoven, Schubert, and Johann Strauss composed a great body of their masterpieces.

Many men of lesser talents also composed and performed there. Among them was Leo's father, Alfred Low-beer. Though piano music was his passion, he supported his wife, Pauline, and Leo, his firstborn, as a clothing wholesaler.

While he hated his job, Alfred made a good living and the family had all the middle-class accoutrements of the time. They lived in a rather small



Carol Lowbeer visits with her father at his Tulsa home.

apartment, but had a cook, a chambermaid, a French governess who spoke in her language, and a hairdresser who paid a daily visit to Mrs Low-Beer.

The first three years of Leo's education were spent with a private tutor, and when he was six years old he began studying piano with one of Vienna's best piano teachers. Leo's younger sister and brother followed in his footsteps.

Later, he attended a private school for boys and began what for him became an annual accomplishment, finishing first in his class. He was aided by self-discipline, driven by natural curiosity and an even stronger yen for approval from his parents, who placed a premium on scholastic and artistic achievement. Some of Leo's happiest childhood moments were spent playing four-handed piano music with his father and attending concerts with his parents.

He was, however, somewhat sickly as a child, given to recurrent middle-ear infections. In that pre-antibiotic time, such infections often resulted in hearing loss. But Vienna was the epitome of medical practice in the early 1900s, and even the most renowned specialists made house calls.

One particular midnight hour, Mr Low-beer summoned a well-known specialist for Leo, who was in great pain from an ear infection. The physician performed a daring procedure on the ear that enabled the infection to drain and thus probably prevented

at least partial deafness. When Leo was ten years old, his appendix was removed, and during his teenage years he had surgery on an infected finger. Cumulatively, these and other physicians had such an enormous impact on the young man that he resolved to go to medical school.

During his third year of high school, in 1914, the foundations of the "Proud Tower" of European civilization started to crack when the Austro-Hungarian empire entered World War I. At first the Great War didn't seem to affect the Low-beers, but even though the family escaped the horrors firsthand, the country eventually was devastated.

In 1918, the Hapsburg monarchy came tumbling down. It was the end of a golden epoch and a way of life that Vienna was never to see again. For the Viennese, it also marked the beginning, in Shirer's words, of three decades of damnation.

During Leo's last three years of high school, from 1918 through 1920, Vienna was filled with hopelessness and humiliation, desolation and starvation. A visiting American journalist named Dawson wrote in 1920 that "the sight of thousands of (children) dying from hunger was a disgrace to civilization." He claimed that 96 percent of Vienna's 340,000 children were "pitifully undernourished."

If so, the Low-beer siblings were in the fortunate four percent. In 1918, Leo had taken up downhill and

slalom skiing. It was exhilarating, stimulating, the perfect antidote to a heretofore sickly and bookish youth, and the perfect distraction from Vienna's wretchedness and misery.

But in 1922, Leo Low-beer's second year at the University of Vienna's School of Medicine, tragedy struck twice. His father died from a stroke and his mother died from cancer. Low-beer sank into a depression. He wrote his Viennese neighbor, Sigmund Freud, asking for help. Freud, who had only recently learned that he was suffering from cancer of the jaw, nevertheless wrote the young medical student a kind letter and recommended he see one of his former students. With the help of the great Dr Alfred Adler, Low-beer recovered and soon made one of the most important decisions of his life.

He visited Professor Jakob Erdheim, head of one of the world's premier pathology institutes at the university's medical school. For whatever reason, Erdheim, who attracted visiting pathologists from around the world, decided to offer the young man a position in the institute. By 1924, under Erdheim's tutelage, Low-beer, still three years away from graduation, was assisting with autopsies and biopsies. Some of the first specimens he saw were from the malignant jaw lesion of Sigmund Freud.

Low-beer had discontinued his piano lessons in 1919, but in 1924 he began earning his way through medical school by playing jazz and tango music in clubs. Less frequently, a rich man would hire him to play chamber music for friends. And once, during a skiing vacation, Low-beer won a contract to play piano for three consecutive summers in a fashionable vacation spot near Salzburg.

The zenith of his musical career in Vienna came in 1925, when he performed in concert at the old Imperial Palace. The splendor and magic of the evening was not diminished by the fact that Low-beer had to hawk tickets to his own concert. He and two other musicians played Piano Trio op. 99 by Franz Schubert. By coincidence, the posters announcing the concert bore a photo of a Viennese plaza, showing the building from which Low-beer's late father, Alfred, had run his clothing business.

Before his graduation from medical school in 1927, Low-beer had become less interested in patients and more interested in the natural history of disease, which he believed was truly understood only in biopsy specimens and, ultimately, autopsies.

Following his internship at Vienna's municipal

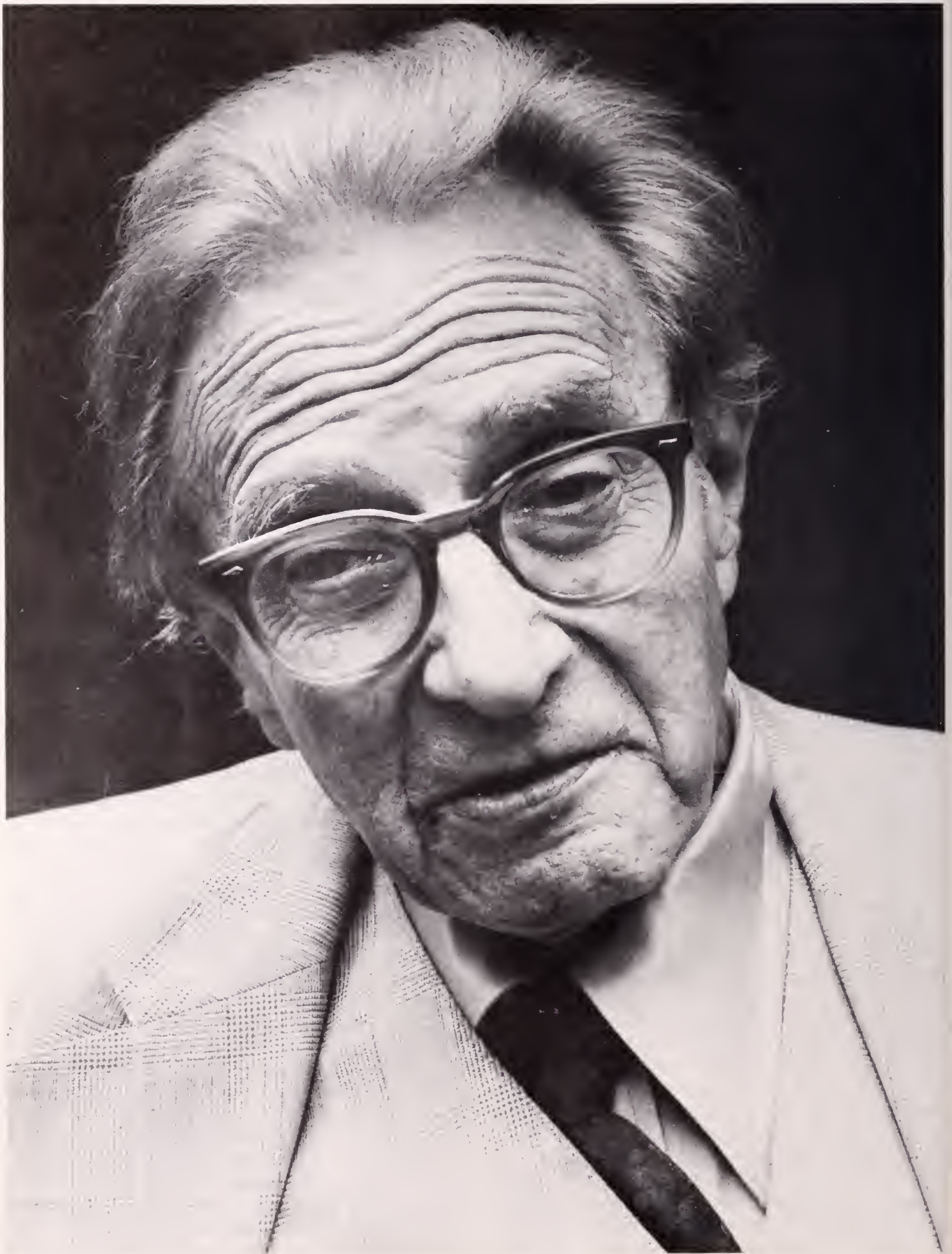
Some of the first biopsy specimens that Lowbeer saw in medical school were from the malignant jaw lesion of Sigmund Freud.

hospital, Dr Low-beer accepted the honor of becoming Erdheim's first assistant. The institute provided autopsies for Vienna's two largest hospitals, a 1,000-bed general hospital and a 3,000-bed geriatric facility. About seven autopsies were performed daily. Most of the cases had died from tuberculosis, but by the late twenties, some of the deceased men who had been diagnosed with tuberculosis were found to have died from lung cancer instead. The increase of cigarette smoking among veterans was another vestige of the Great War.

By 1932, Low-beer was feeling boxed in. He was indebted to his mentor, Erdheim, but he chafed in the older man's immense professional shadow. Since he considered leaving Vienna to be out of the question, Low-beer decided to make his mark in another specialty, internal medicine.

He became a medicine resident the next year and then served until 1938 as chief resident in geriatrics under the leadership of Dr Albert Mueller-Deham. Low-beer was in charge of a 100-bed ward which was primarily for persons over 65 years of age, the severely handicapped, and the indigent.

In 1934, when Chancellor Dollfus disenfranchised many Austrians, he unwittingly paved the way for Hitler's *Anschluss* (union) of Austria and Germany four years later. Throughout the middle thirties, Vienna had a forlorn and dejected air. As one witness



wrote, "there was a gay hopelessness about it that numbed the soul." And it was evident that the majority of the remaining middle class was turning to the Nazis. When Hitler claimed Austria for the Third Reich on March 13, 1938, not a shot of resistance was fired.

Low-beer had been skiing that day. He had skied every weekend he could by the mid-thirties and competed on an increasingly aggressive scale. He won many downhill and slalom events while Hitler was preparing to fulfill the promise he made in the first paragraph of *Mein Kampf*. The reunion of Austria and Germany "was a task to be furthered with every means of our lives."

Though Low-beer never practiced Judaism, and was only half Jewish by blood (from his father's side), he realized by 1938 that Hitler didn't appreciate such distinctions. It was time to leave Vienna and Austria. By sheer accident, he obtained an American sponsor through some mutual skiing friends. That enabled him to get an affidavit to immigrate.

However, before his turn to leave came, he was arrested by two Nazis for allegedly uttering a defamatory remark about a recently slain German ambassador. Low-beer was terrified, because he had been reading in the English-language newspapers about Hitler's "final Jewish solution." Yet, he had sufficient composure to take along the affidavit of support. The document and a fervent promise to leave the country won his release. Five days later, Low-beer, the political refugee, left his beloved Vienna for a new life in the USA.

He had been staying with his sister on Long Island for only a short time when he learned that a small Tulsa hospital was looking for a pathologist. Though he had never heard of Tulsa or Oklahoma, he inquired, and through a series of communications with American pathologists who had studied with Erdheim, Low-beer got several enthusiastic endorsements for the job. As the new year rang in, he was on his way to Tulsa's Morningside Hospital to become a staff pathologist for \$4,000 a year. On the way, he decided to simplify the spelling of his name. Henceforth he would be Dr Leo Lowbeer.

* * *

When Lowbeer began working at Morningside Hospital, he supervised the hospital's three medical technologists, but had to type his own reports. Moreover, as a graduate of a foreign medical school, he couldn't get a medical

**In 1938,
Leo Lowbeer,
the political refugee,
left his
beloved Vienna
for a new life
in the USA.**

license to practice in Oklahoma. Incredibly, he had landed in the only state that would not permit foreign graduates to take competency tests for licensure. However, since most pathologists then were PhDs, pathology wasn't recognized as the practice of medicine. So Lowbeer didn't need the state medical license.

But this law, with its implication of professional inferiority, wasn't the only discrimination that the Viennese physician suffered. Because Austria was a part of the Axis, Lowbeer was required to register as an enemy alien. And, for a time, he was kept under FBI surveillance.

An FBI agent met with Dr Morris Lhevine, chairman of Morningside's department of radiology, to ask why Dr Lowbeer was driving to Arkansas every weekend. Lhevine had no idea. Homesickness, Lowbeer said. This man, who had spent his first 38 years in the Austrian Alps, simply wanted to be in the mountains. So he drove into the Ozarks, where he could stand on some "inclined land."

For the most part, however, he was made to feel welcome in his new home. He made friends easily, especially among the musically inclined, and they began entertaining themselves by playing chamber music in their homes. He also was accepted as a member in the Tulsa Tennis Club.

Lowbeer's findings and report were responsible for the eventual removal of beryllium from fluorescent lights.

From the start, he liked his adopted country and its people. He was attracted by, even if he didn't quite understand, their characteristic twin qualities of brashness and friendliness. Once, on a weekend excursion, he stopped to photograph a beautiful meadow. Drawing nearer, he saw the back of a small sign, which he believed would say, "Keep Off." Instead the sign read, "Enjoy yourself," and Lowbeer thought the sentiment so typically American that he photographed the sign.

Soon after the US entered the war, Lowbeer tried to enlist in the military, but he was rejected for health reasons. Though he had never had active tuberculosis, virtually all health workers in Europe, including Lowbeer, had come in contact with the infectious disease, and his induction physical turned up the evidence.

Lowbeer had an ulterior motive in taking a vacation to New York in 1940. He wanted to visit Gertrude Neuhut, a skiing friend of his from Vienna. Following a skiing trip to the Adirondacks, just as the doctor had planned, they were married. Aside from skiing, the new Mrs Lowbeer also happened to play classical piano music and tennis. Four years later, their daughter, Carol, was born in the hospital where Lowbeer worked. Its name had been changed to Hillcrest. And Leo Lowbeer became an American citizen.

He also was granted a state medical license in 1951 after the state Supreme Court struck down Oklahoma's law barring foreign medical school graduates from applying for medical licensure. Lowbeer passed the exam and obtained evidence indicating that the University of Vienna in 1927 was the equivalent of a grade A (whatever that was) American medical school.

His reputation in American pathology increased in 1946 after he discovered why an abnormal number of farmers and meat packers were afflicted with bone infections or osteomyelitis. A dentist was hospitalized with an abscess on one side of his buttocks. An x-ray showed a lesion of the ilium, indicating probable cancer.

But Lowbeer's laboratory analysis turned up brucella bacteria, perhaps the first time anyone had demonstrated that brucella could infect bones. The source of the dentist's infection was some of his farm hogs that were infected with *Brucella suis*.

Lowbeer began doing medical-legal autopsies for Tulsa and most of eastern Oklahoma in 1951. He enjoyed the detective work but "hated" having to spend time testifying in court. He felt the lawyers were not interested in his testimony: "They were just changing black into white and vice versa."

Still, Lowbeer was interested enough to become Oklahoma's only board certified forensic pathologist in 1959. This occurred just after the state legislature created a medical examiner's office in Oklahoma City to serve the needs of the state. The creation of this office resulted indirectly from one of Lowbeer's autopsy findings.

A certain Mr Doss of Tulsa was admitted to Hillcrest Hospital with stomach pains, diarrhea, and slight anemia. After two or three weeks, his condition improved and he was discharged. But within 48 hours, he was dead. The clinical diagnosis was heart attack.

Lowbeer's autopsy revealed no heart disease, but did turn up severe inflammation in the mucosa of the small and large intestine, which the pathologist recognized as the usual indicator of heavy metal poisoning. Something like arsenic, perhaps. The crime lab's report verified acute arsenic poisoning.

When the widow, Mrs Nannie Doss, was questioned, she readily admitted poisoning her husband. Furthermore, she said, he had poisoned her three previous husbands as well. When their bodies were



Always the scholar, Lowbeer is determined to keep up with medicine's advances.

exhumed and examined, it was clear Mrs Doss had not been lying.

She was sentenced to a state mental hospital, and the publicity generated by the sensational case was used by proponents of creating a state medical examiner's office to get the needed votes in the legislature.

Lowbeer had no interest in the job himself because it "involves too many horrible autopsies, where people have been dead for weeks or months and smell to high heaven." One of the worst, in that sense, was an autopsy he did on a gangster whose body had reposed in the bottom of a water well for several months.

Still, he continued to perform most of Tulsa's medical-legal autopsies until 1975. By then he estimated he had performed some 2,000 forensic pathology studies and more than 12,000 post-mortem examinations. None was more influential than a case that led to an important change in the manufacture of fluorescent lights. A woman came to his office insisting that her husband had not died from natural causes. She demanded and eventually got an order for the exhumation of her husband's body. Lowbeer's autopsy was performed about a year after the man's death. Nevertheless, he made two significant findings. First, he obtained clear evidence of advanced coronary artery disease, which was

attested to on the original death certificate. But, he also discovered that the lungs were filled with little granulomas usually associated with beryllium poisoning.

Though the cause of death was equivocal, Lowbeer wanted to know about the beryllium. The widow said her husband had been helping to raze Tulsa's Douglas Aircraft plant. Part of the job involved clearing out the ceiling lights by smashing them into a flatbed truck. The resulting dust clouds obviously contained beryllium, a constituent of fluorescent lights.

Further investigation showed that all of the men involved in similar work at the Douglas plant subsequently had developed mysterious pulmonary ailments, though no one else had died. Lowbeer's findings and report were responsible for the eventual removal of beryllium from fluorescent lights.

* * *

After attending a scientific meeting in Zurich, Switzerland, in 1957, Lowbeer made the first of four sentimental journeys to his homeland. Though he had no relatives left in Vienna, there were still plenty of old skiing friends around. Outwardly, Vienna hadn't changed much in the nearly 20 years since his forced emigration. But the



city's heart and soul, the artists and the intelligentia, had disappeared forever with the emergence of Adolph Hitler. After visiting his medical school, he concluded that the practice of medicine in Vienna was still pre-World War II.

By 1967, Lowbeer already had exceeded Hillcrest Hospital's mandatory retirement age. He was asked to relinquish the directorship of the pathology department. Though he didn't much like the idea at first blush, he would continue as chief consulting pathologist and director of Hillcrest's Poison Control Center, which he had founded. He would also continue as a consultant to the Federal Aviation Administration, his most time-consuming work. His job consisted of identifying the remains of airplane crash victims. Through this work, he became aware that alcohol is involved in one-third of all light-plane crashes.

Seemingly, his "retirement" would leave him as busy as ever. Paraphrasing the renowned Mark Twain, Lowbeer said, "The rumors of my professional death are greatly exaggerated."

And though this was so, Hillcrest's administrator,

James Harvey paid him this tribute:

"... Dr Lowbeer's personal and professional contributions to the patients and doctors who have come to Hillcrest Medical Center the past 27 years have been enormous. The quality of his service and the genius of his work are well recognized throughout the world."

After his beloved Gertrude died in 1981, he traveled a bit more. He returned to Vienna in 1983 and again in 1985 with his brother and sister. They stayed at the Alpine resort where Lowbeer 40 years before had pounded out jazz and tango music for the pleasure of summer vacationers. The little ivy-covered cottage he had lived in was still there.

Pointing to the majestic range of mountains hovering above them, he recalled several climbing trips, and the mountain meadows filled with edelweiss, where he had read his pathology texts. It seemed incredible, even to Lowbeer himself, that this frail little 84-year-old man had once blazed down those very slopes to win skiing medals.

In Tulsa, on the rare occasions when there was enough snow, he skied the two miles from his home to the hospital. He did this as late as 1984. Only recently, he has cut back his thrice-weekly tennis sessions. He still plays piano once a week; he and a former piano teacher play four-handed piano chamber music.

At 86, he still goes to his Hillcrest office, which is cluttered with professional and personal memorabilia, photographs of his dachshunds and his late wife's rose garden, thousands of slides, numerous award certificates and plaques, and stacks and stacks of journals and books. Probably 15 well-seasoned pipes (of the 300 he owns) are strewn across his desk and tabletops.

He stays there on weekdays, mainly reading journals until about 4:30, determined to keep up with the advances of modern medicine. His life is still an amalgam of his longest-running loves, pathology and music. He has over 3,000 records, and he spends most of his time at home listening to the works of the Great Masters, and now and then remembering the days when the music seemed to echo throughout Vienna. □



News from the Oklahoma State Department of Health

Adult Immunizations

Reflecting on the success of childhood immunization campaigns and the vaccines now available for adults, the Oklahoma State Department of Health (OSDH) has joined a national initiative to encourage adult immunizations. As part of that initiative, the OSDH is sponsoring in October "Adult Immunization Month in Oklahoma."

Although immunizations are often not part of the routine practice of physicians who treat adults, the American College of Physicians, the Centers for Disease Control, and the Association of State and Territorial Health Officials have begun to focus attention on the importance of immunizations for adults. Serious diseases which are preventable by vaccinations continue to occur in adolescents and adults. As an example, over 75% of the reported cases of diphtheria, over 95% of cases of tetanus, and nearly 90% of cases of hepatitis B occur in adults. Seven antigens are of primary concern for immunization of adults: tetanus, diphtheria, measles, rubella, hepatitis B, influenza, and pneumococcus.

Hepatitis B is a particular risk for health care workers, users of illicit injectable drugs, hemodialysis patients, residents of institutions for the retarded, and homosexual men; however, it is estimated that only 20% of the target population has received the full immunization for hepatitis B.

Influenza and invasive pneumococcal infections can be particularly severe in the elderly and persons with chronic underlying illnesses. Only about one-fifth of the people in these groups have been appropriately immunized against either of these diseases.

Several outbreaks of measles and rubella have occurred on college and university campuses, and some serious cases have occurred among health care workers. Ten percent to 15% of young adult women lack protective antibodies against rubella. These women are at risk of having infants with congenital rubella syndrome if they contract rubella while they are pregnant.

Although few in number, most of the remaining cases of diphtheria and tetanus in the US occur in adults. Immunity against these diseases can be maintained with boosters every 10 years.

For more information on the adult immunization campaign, contact the OSDH Immunization Division, 405/271-4073.



RECOMMENDATIONS FOR ADULT IMMUNIZATION*

Adults for whom vaccination is appropriate**	Recommended Vaccination					
	Pneumococcus	Influenza	Measles	Rubella	Tetanus-Diphtheria	Hepatitis B
I. Healthy Adults:						
18-24			x	x	x	
25-64			x	x	x	
65+	x	x			x	
II. Special Groups:						
Women of Childbearing Age			x	x	x	
Immigrant/Eskimo			x	x	x	x ¹
Alcoholic	x	x			x	
Homosexual					x	x
Mortician						x
Health Care Worker		x	x	x	x	x
Factor VIII or IX Recipient						x
Injectable Drug Abuser					x	x
Immunosuppressive Drug Patient	x	x				
Persons with Chronic Condition:						
Pulmonary Disease	x	x				
Cardiac Disease	x	x				
Severe Anemia	x	x				
Renal Failure	x	x				x
Endocrine Disease (Diabetes)	x	x				
Malignancy	x	x				
Asplenia	x	x				

* Prepared by the American College of Physicians, Oklahoma Chapter, in conjunction with Oklahoma State Department of Health

** For advice concerning immunizations for travel and polio please see ACPS

¹ Immigrants and refugees from Asia and sub-Saharan Africa

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*November showdown***Lady killer to be target of 1987 Great American Smokeout**

This year's Great American Smokeout, sponsored by the American Cancer Society (ACS), will be Thursday, November 19. The Smokeout, celebrating its eleventh year, will encourage America's smokers to "give smoking a kick in the butt" by shunning cigarettes for this one day. After all, the promotion says, "if you could quit for just one day, you could kick the habit for life."

Public awareness of Smokeout Day reached an all-time high last year, the ACS reports, with nine out of ten adult Americans aware of the day's purpose. The ACS says nearly 24 million of the

nation's 54.5 million smokers participated in last year's event, topping all previous records.

The ACS adds that although the overall percentage of adult smokers in the population has declined, cigarette smoking is on the rise among young women. Because recent studies suggest that lung cancer has surpassed breast cancer as the leading cancer among women, this year's Smokeout theme will also attack the "lady killer."

For more information about the Great American Smokeout, call your local American Cancer Society.

**Immunization is the adult thing to do**

Most adult Americans give no thought to immunizations for themselves and think that "shots" are just for kids. They couldn't be more wrong. In fact, some immunizations are more important for adults than for children. Unfortunately, physicians are often guilty of the same lapses when they see their adult patients for routine checkups. As a result, millions of adult Americans who should be immunized aren't. And each year thousands of these unimmunized adults die of preventable diseases such as pneumococcal pneumonia and influenza.

Pneumococcal pneumonia is a good example of the problem. There are 85 different strains of *S pneumoniae*, thus theoretically a person could get this disease 85 different times. Fortunately, over 75% of cases are due to just a handful of strains. The current vaccine provides protection against these common strains and thus is 70% to 85% effective. The vast majority of people who get pneumococcal pneumonia recover, but certain individuals are not only more likely to get the disease, they are also more likely to die once infected. This "high risk"

group includes people over the age of 65 years, people with chronic lung or heart disease, people whose spleens have been removed, and those with sickle cell disease. Immunizing these high risk people is an effective way to prevent pneumococcal infection and one injection provides protection for a lifetime. Unfortunately, only 20% of the total high risk population has been immunized.

Influenza outbreaks occur annually in the United States. Over 200,000 deaths due to influenza or its complications occurred in the United States from 1968 through 1972. Influenza vaccine is effective, cheap, and safe. Its effectiveness is dependent on how well the vaccine matches the strain or strains of influenza that are circulating in an individual community. Most years this effectiveness is in the range of 75% to 85%. The currently available vaccines are highly purified and are **not** associated with neurologic complications such as Guillain-Barré syndrome.

Hepatitis B infects an estimated 250,000 people in the United States each year. Hepatitis

(continued)

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Immunization (continued)

B can be transmitted sexually, by infected blood or blood products, or from (infected) mother to child during or shortly after birth. Hepatitis B vaccine is safe and effective but not cheap. A complete series of three injections costs over \$100. Immunization is recommended for medical personnel with significant exposure to blood, hemophiliacs, homosexuals, promiscuous heterosexuals, and IV drug users. Yet at most only 20% of the people who should take this vaccine have been immunized.

Diphtheria and tetanus are two ancient diseases that still occur in the modern world, and one-half of the people acquiring tetanus die. Both tetanus and diphtheria are preventable by a simple, cheap, safe vaccine that should be given routinely every 10 years to all adults. Yet the majority of people who should take this vaccine don't.

Measles and rubella were once thought to be diseases of children. That is no longer true. More than one-half of all cases of both diseases in the United States now occur in young adults. As many as five million adults between the ages of 18 and 29 years may be susceptible to measles. As many as 7 million women of childbearing age in the United States may be susceptible to rubella (and thus directly at risk of having a child with mental retardation or severe congenital deformities if they are unlucky enough to acquire rubella during pregnancy). Both diseases are preventable by a simple injection that provides lifelong immunity.

Human nature, antipathy, ignorance, procrastination, and denial are all partially responsible for the widespread failure of adults to take advantage of the safe, cheap, simple technology of immunizations. Physicians often concentrate on visible, immediate, obvious problems and forget about the importance of immunizations for their adult patients. As a result, the majority of adults who should take one or more immunizations don't get protection from preventable diseases that can either make them miserable or kill them.

The Oklahoma Society of Internal Medicine, along with the Oklahoma Chapter of the

American College of Physicians and the Oklahoma State Board of Health, is helping support a statewide and national campaign to educate the public and physicians that immunization is an adult thing to do. If even one-half of the adults who should be but haven't been immunized get the message, hundreds of lives can be saved in Oklahoma each year.

Lewis Thomas, a wise and witty physician-philosopher, has popularized the concept of true technology versus "paratechnology." The latter is expensive, complicated, poorly or partially effective, and difficult to implement. In contrast, true technology is cheap, effective, and simple. Iron lungs are "paratechnology." They are expensive, complicated, and only partially effective. Cheap, simple, safe polio vaccine is a prime example of true technology, as are influenza and pneumococcal vaccines. But intensive care units wheezing with artificial ventilators hooked up to critically ill people with influenza or pneumococcal pneumonia are modern day proof that "paratechnology" is still with us. A few dollars spent on immunization (true technology) can save much suffering and tremendous expense (paying for paratechnology). Yet this simple fact seems to be lost in the busy shuffle of modern medical practice. Perhaps this is due to poor understanding of the seriousness of preventable diseases. Congenital rubella, severe influenza, and fatal pneumococcal disease are vivid proof this attitude is folly. Others may avoid immunization because of misconceptions about the effectiveness or safety of vaccination. Although no biologic product is without the statistical risk of a major or minor side effect, immunizations for the preceding seven preventable diseases have an unquestioned record of both safety and effectiveness.

It is impossible to explain the widespread lack of compliance for adult immunizations using any rational argument. In the final analysis, it is the apathy of both the medical profession and the public that millions of Americans are not protected against preventable diseases. The solution to the problem is to educate and motivate both groups to immunize adults. Immunization is an adult thing to do.

*Daniel J. Sexton, MD
Oklahoma City*



Photos by Susan Harrison

The Sixth Annual OSMA Medical Student Picnic was held Friday, August 28, at OSMA headquarters in Oklahoma City.

In near perfect fall-like weather, some 200 medical students, spouses, children, physicians, and OSMA staff members gathered for what has become one of the OSMA's most popular events.

Cars zipped by on the expressway as guests filed slowly past serving tables filled with hamburgers, hot dogs, baked beans, potato salad, relishes, and dessert. Those who didn't get their fill the first time around were encouraged to return for seconds.

Among those attending this year's picnic were OSMA President M. Joe Crosthwait, MD (left, standing); Speaker of the House Larry L. Long, MD; President-Elect Ray V. McIntyre, MD; and Auxiliary President Julie Weedn.

The annual event gives new medical students and their families a chance to become acquainted with OSMA and with one another before plunging into their hectic fall schedules. It is organized by OSMA Associate Director Mike Sulzyki (left, seated), who coordinates OSMA student activities.





1987 OSMA Medical Student Picnic



Second study: Heterosexual transmission

Homosexual activity unchanged in areas with low AIDS risk?

High-risk sexual activity may still be the norm among homosexual men in areas with low AIDS incidence, says a study in the *Journal of the American Medical Association*. Another study, of male-to-female transmission of human immunodeficiency virus (HIV) infection, finds repeated contact with an infected partner, and anal intercourse, linked to higher infection risk.

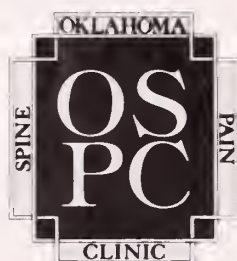
Both studies urge more education and counseling to stem HIV spread. That call is echoed in a third, related report offering physicians suggestions for preventing the transmission of AIDS and other sexually transmitted diseases (STDs).

In the first study, David W. Fleming, MD, now of the Oregon State Health Division, Portland, and colleagues ran HIV tests on serum samples from patients at STD clinics in New Mexico, a state with a low AIDS incidence. One in seven samples from homosexual/bisexual men tested was HIV-positive,

they say.

"The relatively high rate of HIV seropositivity among gay men with other (STDs) indicates that transmission of (AIDS) is continuing in this low-incidence area," they say. "This proportion . . . is likely to increase because measures that prevent the spread of infection have not been uniformly adopted by those at risk." Unprotected sexual activity "may still be the norm for many gay and bisexual men in New Mexico," the authors conclude, citing a survey of gay men in Albuquerque indicating that 76% were practicing receptive anal intercourse but only 10% used a condom more than 10% of the time.

One reason for this, they say, may be the time lag between seroconversion and onset of illness; many of those at risk for AIDS "may be in danger of acquiring infection before the number of reported cases is large enough to motivate significant risk-reducing



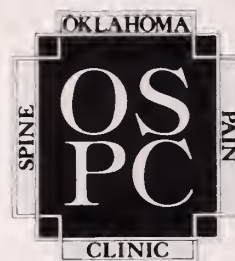
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behavior." The authors suggest that even in low-incidence areas, education and risk-reduction programs should be implemented. They recommend STD clinics as a possible site for such efforts.

The second study, by Nancy Padian, PhD, of the University of California School of Public Health, Berkeley, and colleagues, looks at 97 female sexual partners of 93 HIV-positive males. Most were partners of bisexual men; all had sexual contact within the year before their partner was diagnosed with AIDS or HIV. Overall, 23% of the women were infected, the authors say, concluding, "It is clear that HIV infection is extending from high-risk men to heterosexual women."

Total number of sexual contacts with an infected partner was significantly associated with transmission, as was anal intercourse. "Aside from one case history, this is the first study to find an association between anal intercourse and HIV infection among heterosexuals," the authors say. Many women in the study say their partners used condoms, but protective measures among infected women often were instituted long after sexual activity began and HIV was transmitted.

Although the actual number of women contracting HIV from infected men remains undetermined, the authors estimate that up to 2.5% of women aged 25 to 54 years living in high-incidence areas may be infected. While more research is needed to confirm actual population trends, "empirical results from these and other studies highlight the necessity of educating women and men about ways to reduce risks of heterosexual HIV transmission," the authors conclude.

Finally, a US Preventive Services Task Force report, by Charles R. Horsburgh, Jr., MD, of the University of Colorado Health Sciences Center, Denver, and colleagues, presents recommendations for primary care physicians in preventing specified STDs. These STDs include gonorrhea, syphilis, enteric infections (a group of infections common to gay men), genital warts, herpes simplex, hepatitis B, chlamydia, and AIDS.

Physicians are encouraged to provide patient education aimed at proper treatment, risks of and therapies for the diseases, and for changes in behavior to prevent further spread. Methods of prevention, reporting, and tracing of sexual partners are included in the report. "Further research on methods of patient education and their effectiveness in preventing STDs is sorely needed," the authors conclude.

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When is it appropriate?

Guidelines weigh factors in risky carotid endarterectomy

A study in the *Journal of the American Medical Association* outlines guidelines for when to perform carotid endarterectomy, the controversial procedure designed to head off stroke by surgically clearing the carotid artery.

Carotid endarterectomy, performed more than 100,000 times a year in the US, can be risky, and studies have questioned its effectiveness. In an effort to develop guidelines for its appropriate use, David B. Matchar, MD, of the Duke University Medical Center, Durham, NC, and Stephen G. Pauker, MD, of the Tufts University School of Medicine, Boston, used computer modeling to simulate possible outcomes for a cohort of patients at risk for stroke.

The researchers figured in published estimates of surgical risk and efficacy, annual stroke rate, and nonstroke mortality. Surgical risk and efficacy and stroke risk were found to be the most important factors in determining when the surgery is appropriate. The authors then produced surgery guidelines based on estimated risk of future stroke.

The study says the surgery is not indicated for patients with a stroke risk of less than 3% per year. For a 3% to 5% stroke risk, low-risk surgery can be expected to provide a benefit of at most three months of quality life, depending on surgical efficacy, the authors say.

However, for stroke risk of 5% to 10%, even high-risk surgery is favored, if surgical efficacy is greater than 30%. For stroke risk over 10%, even high-risk, low-efficacy surgery should be considered, the authors say. "The challenge to advocates of carotid endarterectomy is to develop a cost-effective strategy for identifying patients at high risk for stroke," they conclude.



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Harvard study formulates new resource-based reimbursement

Rapidly rising health care costs, and the many efforts to control them, have policymakers and researchers looking for new ways of paying for physician services that are both fair and equitable.

A report in the *Journal of the American Medical Association (JAMA)*, by William C. Hsiao, PhD, of the Harvard School of Public Health, Boston, and colleagues, describes a study now under way to develop such an alternative system for establishing payment rates for doctors' services and procedures.

The proposed system, called the Resource-Based Relative Value Scale (RBRVS), would measure resources that physicians put into care in order to establish relative values for services and procedures. Such "resource inputs" to be measured include the time involved in preparing for, providing, and following up services and procedures; care intensity; practice costs, including malpractice premiums; and the cost of specialty training. These factors would be combined to produce an RBRVS expressed in nonmonetary units.

"Such a scale has a number of possible uses while seeking to avoid the price distortions that appear to be inherent in charge-based scales," the authors say. The *JAMA* report describes the study's design and methods. Final results are expected by the summer of 1988.

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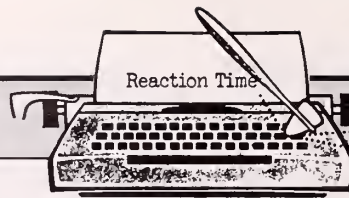
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Poke at patient pirating prompts praise

To the Editor: I always read and appreciate your editorials but don't take the time to let you know. I certainly agree with your editorial in the August JOURNAL ["Yo Ho Ho!"] and hope you will keep on pounding on it.

If you see Joe Crosthwait tell him I certainly agree with his article on the President's Page. Keep up the good work.

Bruce R. Hinson, MD
Enid

Doctor cites 'increasing disinclination' to practice

The following letter was addressed to Oklahoma County Medical Society President Irwin H. Brown, MD:

Dear Doctor Brown: When I first became a member of Oklahoma County Medical Society over forty years ago, the prospect of being seventy just never crossed my mind (but then the prospect of calling a practical nurse in El Paso to see if it is permissible to put a sick patient in the hospital never crossed my mind either).

But, I am and it has and thus this letter.

I would like to request that the Society consider my request for Life Membership and if favorably

considered forwarded to OSMA and AMA.

Sincerely,
Scott Hendren, MD
Oklahoma City

Dr Hendren's list of reasons for the request included the following:

3. Unable to conduct a sufficiently active practice to pay dues or assessments without hardship because of:

D. Other (Describe): A variety of initials including, but not limited to, UR, QC, SI, IS, PRO, HMO, PPO, Pre-Cert., etc, etc, etc. All of these contributing to an increasing disinclination to "market my services in a competitive manner." □

BOOK SHOP

American Assassins. The Darker Side of Politics. By James W. Clarke. Princeton, New Jersey: Princeton University Press, 1982, pp 321, illus, price \$18.50.

Professor James W. Clarke, a political scientist at the University of Arizona, has written an interesting and useful book. He has utilized original sources to study the lives, including social and political aspects, of sixteen assassins and would-be assassins in America. The targets were ten United States presidents and four other prominent figures.

The book is divided into certain major categories under each of which he discusses certain assassins. Under "Region and Class," the first category, he discusses John Wilkes Booth (Abraham Lincoln, 1865) and Leon Czolgosz (William McKinley, 1901). Other major categories include "Nationalism,"

"Rejection," "the Feminine Dimension," and "Family and Money." Of the sixteen persons he identified, only three would be considered not guilty by virtue of insanity. These were Richard Lawrence (Andrew Jackson, 1835), Charles J. Guiteau (James A. Garfield, 1881), and John Schrank (Theodore Roosevelt, 1912).

Although John F. Hinkley, Jr., is mentioned from time to time in the book, the book does not contain a separate chapter about him. There are discussions of assassins during recent years, including Arthur H. Bremer (George Wallace, 1972), Dr Carl Austin Weiss (Huey Long, 1935), and James Earl Ray (Martin Luther King, Jr., 1968), as well as the attackers of Presidents John F. Kennedy, Harry S. Truman, Franklin D. Roosevelt, Richard M. Nixon, Gerald R. Ford, and Senator Robert F. Kennedy.

The section on each individual is concise and well written and provides interesting insights into the background of each of the proven or alleged assassins. The author arrives at no final solution to the problem of the assassin. He recommends handgun control but quickly points out that even this would not have prevented several of the deaths. He also notes the heavy social costs of increased domestic surveillance to enforce control.

The book concludes with a final chapter that reviews and summarizes some of the influences and what possible preventive measures can be used in the future. References are given in a final chapter and are quite extensive.

Clarke faults the discipline of psychiatry and is critical of psychiatrists for the lack of scientific method employed and the dogged adherence to an "out-worn Oedipal Complex theory."

This new book will be of interest to all concerned with the topic of assault on public figures. It is well written and well documented.

*Harris D. Riley, Jr., MD
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LIBRIUM®

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders; short-term relief of anxiety symptoms, acute alcohol withdrawal symptoms, preoperative apprehension and anxiety. Usually not required for anxiety or tension associated with stress of everyday life. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported after a recommended dose, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported after abrupt cessation of extended use of excessive doses are similar to those seen with barbiturates. Milder symptoms reported infrequently when continuous therapy is abruptly ended. Avoid abrupt discontinuation; gradually taper dosage.

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. **Oral—Adults:** Mild and moderate anxiety disorders and symptoms, 5 or 10 mg t.i.d. or q.i.d. severe states, 20 or 25 mg t.i.d. or q.i.d. **Geriatric patients:** 5 mg b.i.d. to q.i.d. (See Precautions).
Supplied: Librium® (chlordiazepoxide HCl/Roche) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in boxes of 4 reverse-numbered cards of 25, and in boxes containing 10 strips of 10. Libritabs® (chlordiazepoxide/Roche) Tablets, 5 mg and 10 mg—bottles of 100 and 500; 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.

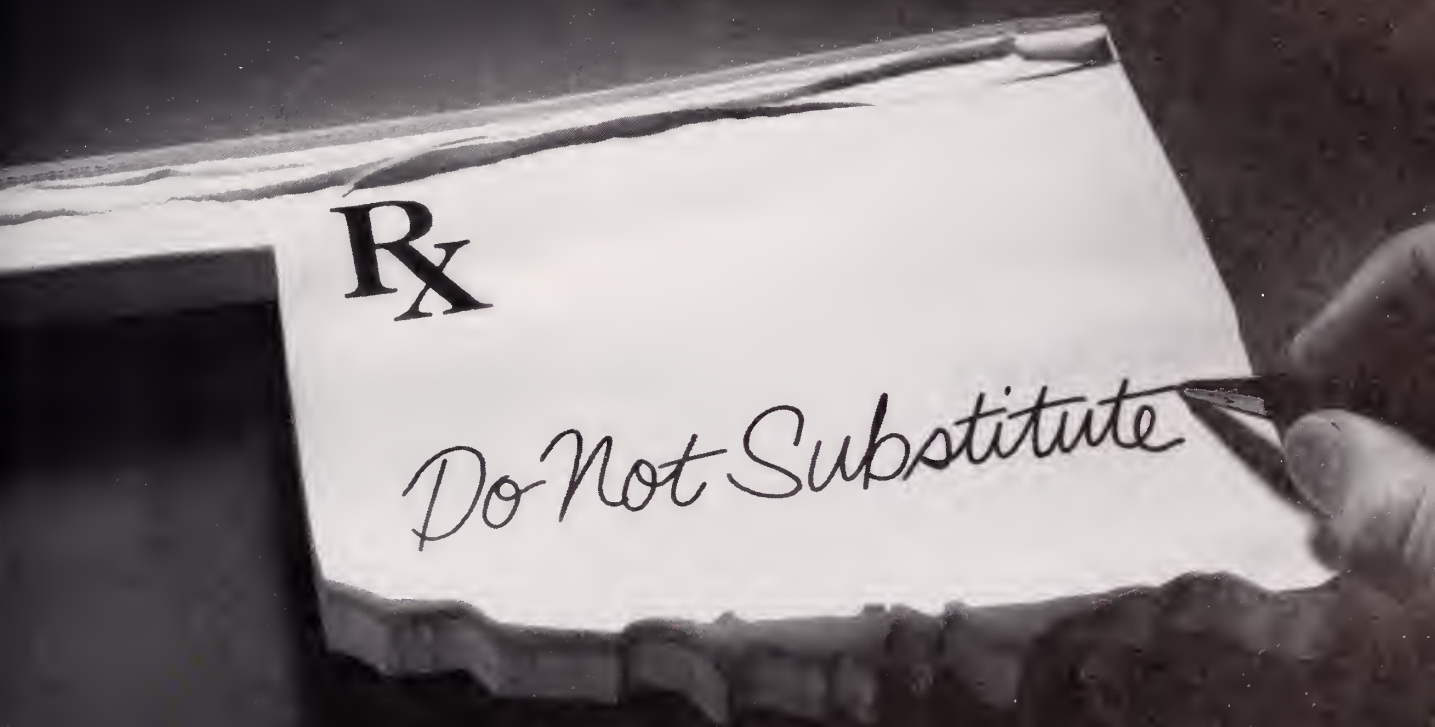
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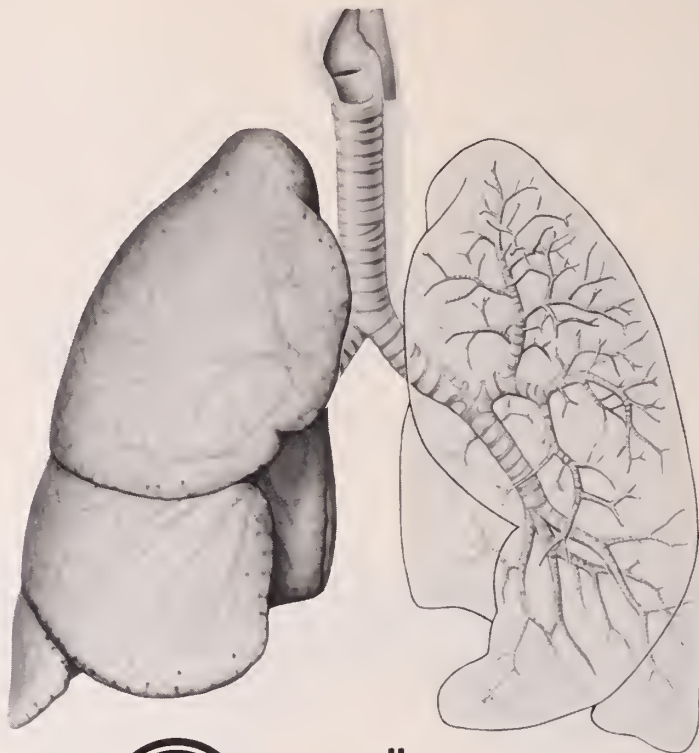


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offers effectiveness against the major causes of bacterial bronchitis

Haemophilus influenzae, *Streptococcus pneumoniae*
(ampicillin-susceptible and ampicillin-resistant)

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor[®] (cefactor)

Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication:
Known allergy to cephalosporins.

Warnings:
CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients. Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness,

insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.

- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinistest[®] tablets but not with Tes-Tape[®] (glucose enzymatic test strip, Lilly).

[072886R]

PA 8794 AMP

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

For more prescribing, see complete prescribing information in SK&F CO. literature or PDR. The following is a brief summary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine output less than one liter/day, the elderly and diabetics with suspected confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, patient should stop nursing. Adequate information on use in children not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or aggravation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity, hydrochlorothiazide. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide availability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin (ACTH). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, or idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, granulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to reverse the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. Few occurrences of acute renal failure have been reported in patients with 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine, both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), increasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is common with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, mouth, anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, or gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, esthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, adenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', though a causal relationship has not been established.

Supply: 'Dyazide' is supplied as a red and white capsule, in bottles of 100 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

S-DZ:L42

In Hypertension*... When You Need to Conserve K⁺

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Serum K⁺ and BUN should be checked periodically (see Warnings and Precautions).



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nd PREMARIN®

**Proven benefits beyond relief
of vasomotor symptoms**

**No other estrogen proven
effective for osteoporosis**

Only conjugated estrogens tablets have established efficacy in both osteoporosis¹ and vasomotor symptoms* at 0.625 mg/day. No other estrogen, oral or transdermal, has established clinical evidence or minimum effective dose in both indications.

No estrogen proven safer

PREMARIN is the most extensively tested estrogen, with an unsurpassed record of long-term safety.

And clinical evidence shows a significantly reduced risk of endometrial hyperplasia when cycled with a progestin.²

PREMARIN®
(conjugated estrogens tablets)

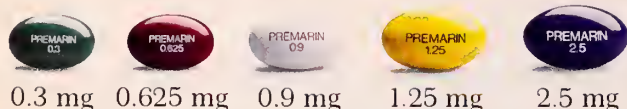
Most trusted for more reasons

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary
of prescribing information.

For moderate-to-severe
vasomotor symptoms and
for osteoporosis

PREMARIN® (conjugated estrogens tablets)



The appearance of these tablets is a trademark of Ayerst Laboratories.

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS)

PREMARIN® Brand of conjugated estrogens tablets, USP

PREMARIN® Brand of conjugated estrogens Vaginal Cream, in a nonliquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA. Three independent, case-controlled studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case-controlled studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semi-annual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equi-estrogenic doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing, in later life, a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case-controlled study estimated a 4.7-fold increased risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17 α -dihydroequilin, together with smaller amounts of 17 α -estradiol, equilenin, and 17 α -dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP). Moderate-to-severe vasomotor symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) Osteoporosis (abnormally low bone mass). Atrophic vaginitis. Kraurosis vulvae. Female castration. PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae.

PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy. (See Boxed Warning.) 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Estrogens have been reported to increase the risk of endometrial carcinoma (see Boxed Warning). However, a recent large, case-controlled study indicated no increase in risk of breast cancer in postmenopausal women. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

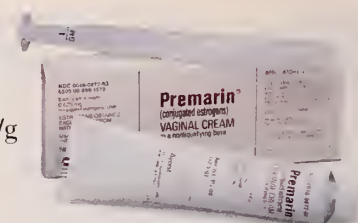
Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism, and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

For atrophic vaginitis

PREMARIN® (conjugated estrogens)

Vaginal
Cream

0.625 mg/g



Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention, such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Pre-existing uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. It jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not yet complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:
a. Increased sulfobromophthalein retention
b. Increased prothrombin and factors VII, VIII, IX, and X, decreased antithrombin 3, increased norepinephrine-induced platelet aggregability
c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T₄ by column, or T₄ by radioimmunoassay. Free T₃ resin uptake is decreased, reflecting the elevated TBG. Free T₄ concentration is unaltered.
d. Impaired glucose tolerance
e. Decreased pregnandiol excretion
f. Reduced response to methylparathion test
g. Reduced serum tolact concentration
h. Increased serum triglyceride and phospholipid concentration

As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

Long-term, continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. However, in a recent, large case-controlled study of postmenopausal women there was no increase in risk of breast cancer with use of conjugated estrogens.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow, dysmenorrhea, premenstrual-like syndrome, amenorrhea during and after treatment, increase in size of uterine fibromyomata, vaginal candidiasis, change in cervical erosion and in degree of cervical secretion, cystitis-like syndrome, tenderness, enlargement, secretion (of breasts), nausea, vomiting, abdominal cramps, bloating, cholestatic jaundice, chloasma or melasma which may persist when drug is discontinued, erythema multiforme, erythema nodosum, hemorrhagic eruption, loss of scalp hair, hirsutism, sleepiness of corneal curvature, intolerance to contact lenses, headache, migraine, dizziness, mental depression, chorea, increase or decrease in weight, reduced carbohydrate tolerance, aggravation of porphyria, edema, changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

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1. *Given cyclically for short-term use only.* For treatment of moderate-to-severe vasomotor symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 mg to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.
2. *Given cyclically.* Osteoporosis. Female castration. Osteoporosis — 0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off). Female castration — 1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

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Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals. Usual dosage range: 2 g to 4 g daily, intravaginally, depending on the severity of the condition. Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

1. Lindsay R, Hart DM, Clark DM. The minimum effective dose of estrogen for prevention of postmenopausal bone loss. *Obstet Gynecol* 1984;63:759-763. 2. Studd JWW, Thom MH, Paterson MEL, et al. The prevention and treatment of endometrial pathology in postmenopausal women receiving exogenous estrogens. In Pasetto N, Paoletti R, Ambrosi JL (eds). *The Menopause and Postmenopause*. Lancaster, England: MTP Press Ltd, 1980, chap 13.

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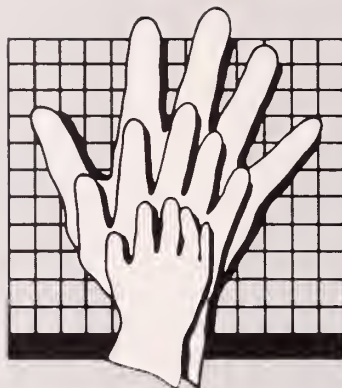
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Articles submitted for publication, including Annual Meeting papers, become the sole property of the JOURNAL and must not have been published elsewhere. The Editorial Board reserves the right to edit any material submitted. Manuscripts must be typewritten, double-spaced, and submitted in duplicate. Receipt of manuscripts will be acknowledged, and unpublished manuscripts will be returned. The JOURNAL does not assume responsibility for the statements or opinions of any contributor.

Style

All manuscripts should adhere to the style adopted by the American Medical Association as illustrated in *JAMA* and detailed in the AMA's *Manual for Authors & Editors*. Footnotes, bibliographies, and legends for illustrations should be typewritten, double-spaced, on separate sheets. References are to be listed in the order of their appearance in the article.

Illustrations

Illustrations other than the author's will not be accepted for publication unless accompanied by written permission from the original source. Illustrations should be labeled with the author's name and must be numbered in the order in which they are referred to in the article. The quality of all illustrations must be in keeping with the quality of the magazine.

News

Readers are encouraged to submit news items of interest to Oklahoma physicians. Where dates of meetings, etc., are important, please remember that each issue closes on the first day of the *preceding* month and reaches subscribers in the latter half of the month of publication.

Reprints

Authors will receive reprint order forms from the Transcript Press, 222 East Eufaula, Norman, Oklahoma 73069, prior to publication of their articles. Other requests for reprints must be made to the Transcript Press within 30 days after publication.

Back Issues

Microfilm copies of back issues of the JOURNAL can be purchased from University Microfilms International, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

Career Spouse Membership

One of the most important objectives in the area of membership is to identify and attract the career, or working, spouses to the medical auxiliary. These individuals have unique talents and are a potential source for active members. Normally it is quite difficult to recruit new members to an organization with a commitment to become actively involved in the pursuit of its goals. Career spouses are usually very active, with limited time, but present a challenge for us to directly involve them in the medical auxiliary.

Because he or she is married to a physician, a career spouse's role in the partnership takes on greater responsibility than normal. Besides house-keeping, shopping, bill paying, child raising, taxi service, chief cook and bottle washer, etc, etc, etc, they choose to be involved in a typical 9 to 5 job. Whether learned in college or on the job, their careers leave little time for personal activities. This time is usually selfishly guarded, and rightly so. However, their participation in the medical auxiliary is very important.

The career spouses' ability to articulate auxiliary goals and programs has the potential for reaching a vast number of people. Most of them are fairly organized, highly motivated, and are high achievers. When the benefits of participating in the auxiliary are fully explained to them, they usually commit at least a portion of their time to this organization which means so much to the medical family. Without their involvement, the auxiliary loses the very uniqueness these individuals utilize in the pursuit of their own careers.

We must interest the career spouses by contacting them directly to let them know just what the auxiliary is doing and how much their help is needed. We must invite them to meet with us and share our camaraderie and our concerns about medical issues. We must inform them about our interests in community health projects and in educating the public about medical issues. We must inform them about the real issues in legislation which threaten

the physician's practice and what we as a group can do to affect that. We must involve them as members and give them responsibilities which rely on their personal talents and interests.

Special efforts can be made to attract the career spouses to become a part of the auxiliary. Meetings can be held during the lunch hour or in the evenings; meeting topics can cover areas of general interest to working people. Family days with picnics and a bonfire can help to establish better rapport. Personal contacts can be made to determine what level of activity they would prefer to have in our group and give us a better understanding of their needs as well.

Many motivated people are needed for an organization to help with community education and for special medically related projects. When it comes to legislation, I'm reminded of the many hours medical residents have spent not knowing when they would eat a meal nor when they would get a chance to sleep. The sacrifice of personal pleasures in order to fully commit to a medical career was a necessity. Now, the lifestyle of that autonomous physician, practicing medicine in a manner he or she sees fit according to well-trained judgment and at a salary commensurate with skills and dedication, is being threatened.

As a group, the medical auxiliary can help to affect the outcome of legislation that is trying to regulate the physician's decisions, methods of treatment and, indirectly, their salaries. And when it comes to fellowship, what more interesting or diverse group of people could there be than friends who share these same concerns and understandings at some level and still recognize their own personal commitments to a career? Help us identify and recruit these potential new members.

For additional information on career spouse membership, contact me or the Oklahoma State Medical Association office at 1-800-522-9452.

John K. Johnson
OSMAA Career Spouse Coordinator

THE LAST WORD

■ **Bernard L. Swartz, MD**, a Tulsa plastic surgeon, was honored recently by the American Red Cross for his contribution to their transplantation services.

■ **Frederic W. Stearns, MD**, was featured in a Member Profile article in the August issue of *Tulsa Medicine*. The article describes Dr Stearns's activities as a flight surgeon for his Air National Guard unit in Tulsa.

■ **"DNA Probes in the Practice of Medicine"** is the subject of an AMA conference to be held in Los Angeles next month. Scheduled for Friday and Saturday, November 13 and 14, the conference is part of a continuing series on biotechnology in medicine. It will be similar to a conference held in April in Washington, DC. The program will feature experts on DNA technology from around the country and was developed to provide clinical pathologists, microbiologists, geneticists, and others with an understanding of how DNA-based diagnostics are being applied to their specialties. Registration information may be obtained by calling 1-800-621-8335.

■ **Homelessness has become a problem** for many AIDS patients in New York City and is affecting their care, says a letter in the *Journal of the American Medical Association*. Ramon A. Torres, MD, of St. Vincent's Hospital and Medical Center, New York City, and colleagues say 13% of the 231 AIDS patients diagnosed at their hospital between 1981 and 1985 were identified as homeless upon admission. These patients, who lived in the streets or public shelters, were more likely to be black or Hispanic and to be intravenous drug abusers, the letter continues. The authors report the homeless patients remained hospitalized longer than other AIDS patients but often did not complete their courses of care or were lost to medical follow-up. "Increasing numbers of AIDS patients remain hospitalized solely because of homelessness, and others are inappropriately discharged to shelters or the streets," the letter states.

■ **Delivery of the 1988-1989 OSMA Medical Directory** is expected in November. Each OSMA member will automatically receive one copy of the directory at no charge. Additional directories may be ordered at a cost of \$12.50 per copy for members and \$20.00 for nonmembers. Bulk orders of ten or more are \$10.00 per copy. To order, send name and address, number of copies desired, and payment to: Oklahoma State Medical Association, 601 Northwest Expressway, Oklahoma City, OK 73118.

■ **The Oklahoma Occupational Medical Association** will hold its Fall Educational Conference on Friday and Saturday, November 13 and 14, at Tulsa's Westin Hotel. This year's conference is entitled "Current Trends in Occupational Medicine". For additional information about the conference, contact **Robert M. Mahaffey, MD**, at the University of Oklahoma Tulsa Medical College, 9912 East 21st Street, Tulsa, OK 74129.

■ **The American Lung Association of Green Country**, at its recent annual meeting, announced its establishment of the **George W. Prothro Award** for Distinguished Community Service, named in recognition of Dr Prothro's many years of community service in Tulsa. Dr Prothro is a former president of the American Lung Association of Oklahoma. At the same meeting, **Lofty L. Basta, MD**, received the Green Country Excellence Award for Long Term Impact to Lung Health. Dr Basta is developing a comprehensive health education program for Tulsa schools.

■ **D. Robert McCaffree, MD**, and **Robert E. Sheldon, MD**, of Oklahoma City have been selected to participate in the Leadership VI civic training program sponsored by Leadership Oklahoma City, Inc. The nine-month program is designed to familiarize future community volunteer leaders with elements important to effective community leadership, such as health care, education, fund raising, and transportation. □

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Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus bradycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Use in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those at barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring

reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

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Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias at the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.

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[†]See Warnings and Precautions.

Please see brief summary of prescribing information on the next page.

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diltiazem HCl/Marion PLUS SAFETY

Usual maintenance dosage range: 180-360 mg/day

Brief Summary

Professional Use Information

CARDIZEM[®]

(diltiazem HCl) 30 mg, 60 mg, 90 mg, and 120 mg Tablets

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

- 1. Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
- 2. Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
- 3. Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
- 4. Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies,

oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in *in vitro* bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Rx

*Cardizem[®]
(diltiazem HCl)*

☐ 60 mg ☐ 90 mg
☐ 120 mg

Sig: tid

- Cardiovascular:** Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.
- Nervous System:** Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.
- Gastrointestinal:** Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.
- Dermatologic:** Ptelechiae, pruritus, photosensitivity, urticaria.
- Other:** Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarthralgia pain, polyuria, sexual difficulties.

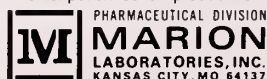
The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.


Issued 9/86

See complete Professional Use Information before prescribing.

References: 1. Schroeder JS. *Mod Med* 1982;50(Sept):94-116. 2. Cahn PF, Braunwald E. Chronic ischemic heart disease, in Braunwald E (ed): *Heart Disease: A Textbook of Cardiovascular Medicine*, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. 3. O'Rourke RA. *Am J Cardiol* 1985;56:34H-40H. 4. McCall D, Walsh RA, Frohlich ED, et al. *Curr Probl Cardiol* 1985;10(8):6-80. 5. Frishman WH, Charlap S, Goldberg J, et al. *Am J Cardiol* 1985;56:41H-46H. 6. Shapiro W. *Consultant* 1984;24(Dec):150-159. 7. O'Hara MJ, Khurmi NS, Bowles MJ, et al. *Am J Cardiol* 1984;54:477-481. 8. Strauss WE, McIntyre KM, Pansil AF, et al. *Am J Cardiol* 1982;49:560-566. 9. Feldman RL, Pepine CJ, Whittle J, et al. *Am J Cardiol* 1982;49:554-559.

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	CONSTIPATION	RESPIRATORY DEPRESSION	SEDATION	EMESIS	PHYSICAL DEPENDENCE
HYDROCODONE		X			X
CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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The original hydrocodone analgesic.

Specify "Dispense as written" for the original hydrocodone analgesic.

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.

WARNINGS:

Drug Abuse and Dependence: VICODIN® is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.

Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS:

Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.

Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.

Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.

Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.

Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression: (See WARNINGS.)

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.

The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982.

S685

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978

2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.

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Brief Summary. Consult the package literature for prescribing information. Indications and Usage: Keflet® Tablets (cephalexin, Dista) are indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Respiratory tract infections caused by *Streptococcus pneumoniae* and group A β -hemolytic streptococci (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. Keflet is generally effective in the eradication of streptococci from the nasopharynx; however, substantial data establishing the efficacy of Keflet in the subsequent prevention of rheumatic fever are not available at present.)

Otitis media due to *S. pneumoniae*, *Haemophilus influenzae*, staphylococci, streptococci, and *Neisseria catarrhalis*

Skin and skin structure infections caused by staphylococci and/or streptococci

Bone infections caused by staphylococci and/or *Proteus mirabilis*

Genitourinary tract infections, including acute prostatitis, caused by *Escherichia coli*, *P. mirabilis*, and *Klebsiella sp.*

Note: Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

Contraindication: Keflet is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEPHALEXIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLINS. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to Keflet.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Usage in Pregnancy: Safety of this product for use during pregnancy has not been established.

Precautions: General: Patients should be followed carefully so that any side effects or unusual manifestations of drug idiosyncrasy may be detected. If an allergic reaction to Keflet occurs, the drug should be discontinued and the patient treated with the usual agents (eg, epinephrine or other pressor amines, antihistamines, or corticosteroids).

Prolonged use of Keflet may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Keflet should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

As a result of administration of Keflet, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B: The daily oral administration of cephalexin to rats in doses of 250 or 500 mg/kg prior to and during pregnancy, or to rats and mice during the period of organogenesis only, had no adverse effect on fertility, fetal viability, fetal weight, or litter size. Note that the safety of cephalexin during pregnancy in humans has not been established.

Cephalexin showed no enhanced toxicity in weanling and newborn rats as compared with adult animals. Nevertheless, because the studies in humans cannot rule out the possibility of harm, Keflet should be used during pregnancy only if clearly needed.

Nursing Mothers: The excretion of cephalexin in the milk increased up to 4 hours after a 500-mg dose; the drug reached a maximum level of 4 μ g/mL, then decreased gradually, and had disappeared 8 hours after administration. Caution should be exercised when Keflet is administered to a nursing woman.

Adverse Reactions: Gastrointestinal: Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely. The most frequent side effect has been diarrhea. It was very rarely severe enough to warrant cessation of therapy. Dyspepsia and abdominal pain have also occurred. As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.

Hypersensitivity: Allergic reactions in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson Syndrome, or toxic epidermal necrolysis have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported.

Other reactions have included genital and anal pruritus, genital moniliasis, vaginitis and vaginal discharge, dizziness, fatigue, and headache. Reversible interstitial nephritis has been reported rarely. Eosinophilia, neutropenia, thrombocytopenia, and slight elevations in SGOT and SGPT have been reported.


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A woman with dark hair, wearing a bright orange button-down shirt and dark trousers, sits alone at a white metal table in what appears to be an outdoor cafe. She is looking down with a somber expression. The table has a white cup and saucer on it. In the background, several other identical white metal tables and chairs are visible, all empty. The setting is against a dark, textured wall.

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totally prevented for 4 to 6 months in up to
75% of patients.)

*Please see last page of this advertisement for
brief summary of prescribing information.*

ZOVIRAX[®] (acyclovir) CAPSULES

**Help free your
patients from
recurrences.**

Daily therapy

Coping with genital herpes is rarely easy. For some, the worst part is the pain and discomfort of frequent attacks — month after month, year after year. For others, the emotional burden presents a more difficult problem, leading to social isolation, anxiety, and diminished self-esteem.

Prevent or reduce recurrences

Although your patients have to live with herpes, they shouldn't have to suffer. Daily therapy with ZOVIRAX CAPSULES can help free them from the cycle of recurrent genital herpes. For many, one capsule three times a day can suppress recurrences completely while on therapy.

Generally well tolerated

Daily therapy with ZOVIRAX CAPSULES is generally well tolerated. The most frequent adverse reactions reported during clinical trials were headache, diarrhea, nausea/vomiting, vertigo, and arthralgia.

The physical and emotional difficulties posed by genital herpes are unique for each patient. The frequency and severity of recurrent episodes, as well as the emotional impact of the disease, should be considered when selecting daily therapy with ZOVIRAX CAPSULES.

*Please see brief summary of
prescribing information on next page.*



Prevent recurrences month after month*

ZOVIRAX®

(acyclovir) CAPSULES

Brief Summary

INDICATIONS AND USAGE: Zovirax Capsules are indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes in certain patients.

The severity of disease is variable depending upon the immune status of the patient, the frequency and duration of episodes, and the degree of cutaneous or systemic involvement. These factors should determine patient management, which may include symptomatic support and counseling only, or the institution of specific therapy. The physical, emotional and psycho-social difficulties posed by herpes infections as well as the degree of debilitation, particularly in immunocompromised patients, are unique for each patient, and the physician should determine therapeutic alternatives based on his or her understanding of the individual patient's needs. Thus Zovirax Capsules are not appropriate in treating all genital herpes infections. The following guidelines may be useful in weighing the benefit/risk considerations in specific disease categories:

First Episodes (primary and nonprimary infections — commonly known as initial genital herpes):

Double-blind, placebo-controlled studies have demonstrated that orally administered Zovirax significantly reduced the duration of acute infection (detection of virus in lesions by tissue culture) and lesion healing. The duration of pain and new lesion formation was decreased in some patient groups. The promptness of initiation of therapy and/or the patient's prior exposure to Herpes simplex virus may influence the degree of benefit from therapy. Patients with mild disease may derive less benefit than those with more severe episodes. In patients with extremely severe episodes, in which prostration, central nervous system involvement, urinary retention or inability to take oral medication require hospitalization and more aggressive management, therapy may be best initiated with intravenous Zovirax.

Recurrent Episodes:

Double-blind, placebo-controlled studies in patients with frequent recurrences (6 or more episodes per year) have shown that Zovirax Capsules given for 4 to 6 months prevented or reduced the frequency and/or severity of recurrences in greater than 95% of patients. Clinical recurrences were prevented in 40 to 75% of patients. Some patients experienced increased severity of the first episode following cessation of therapy; the severity of subsequent episodes and the effect on the natural history of the disease are still under study.

The safety and efficacy of orally administered acyclovir in the suppression of frequent episodes of genital herpes have been established only for up to 6 months. Chronic suppressive therapy is most appropriate when, in the judgement of the physician, the benefits of such a regimen outweigh known or potential adverse effects. In general, Zovirax Capsules should not be used for the suppression of recurrent disease in mildly affected patients. Unanswered questions concerning the human relevance of *in vitro* mutagenicity studies and reproductive toxicity studies in animals given very high doses of acyclovir for short periods (see Carcinogenesis, Mutagenesis, Impairment of Fertility) should be borne in mind when designing long-term management for individual patients. Discussion of these issues with patients will provide them the opportunity to weigh the potential for toxicity against the severity of their disease. Thus, this regimen should be considered only for appropriate patients and only for six months until the results of ongoing studies allow a more precise evaluation of the benefit/risk assessment of prolonged therapy.

Limited studies have shown that there are certain patients for whom intermittent short-term treatment of recurrent episodes is effective. This approach may be more appropriate than a suppressive regimen in patients with infrequent recurrences.

Immunocompromised patients with recurrent herpes infections can be treated with either intermittent or chronic suppressive therapy. Clinically significant resistance, although rare, is more likely to be seen with prolonged or repeated therapy in severely immunocompromised patients with active lesions.

CONTRAINDICATIONS: Zovirax Capsules are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulation.

WARNINGS: Zovirax Capsules are intended for oral ingestion only.

PRECAUTIONS: General: Zovirax has caused decreased spermatogenesis at high doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS — Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage and length of treatment should not be exceeded (see DOSAGE AND ADMINISTRATION).

Exposure of Herpes simplex isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of Herpes simplex virus to acyclovir and clinical response to therapy has yet to be established.

Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy.

Drug Interactions: Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of 50, 150 and 450 mg/kg given by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. In 2 *in vitro* cell transformation assays, used to provide preliminary assessment of potential oncogenicity in advance of these more definitive life-time bioassays in rodents, conflicting results were obtained. Acyclovir was positive at the highest dose used in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative in another transformation system considered less sensitive.

In acute studies, there was an increase, not statistically significant, in the incidence of chromosomal damage at maximum tolerated parenteral doses of 100 mg/kg acyclovir in rats but not Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters. In addition, no activity was found after 5 days dosing in a dominant lethal study in mice. In 6 of 11 microbial and mammalian cell assays, no evidence of mutagenicity was observed. At 3 loci in a Chinese hamster ovary cell line, the results were inconclusive. In 2 mammalian cell assays (human lymphocytes and L5178Y mouse lymphoma cells *in vitro*), positive responses for mutagenicity and chromosomal damage occurred, but only at concentrations at least 400 times the acyclovir plasma levels achieved in man.

Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg/day, p.o.) or in rats (25 mg/kg/day, s.c.). At 50 mg/kg/day s.c. in the rat, there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day. No effect upon implantation efficiency was observed when the same dose was administered intravenously. In a rat peri- and postnatal study at 50 mg/kg/day s.c., there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the F₁ generation. Although not statistically significant, there was also a dose related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size. However, at a

maximum tolerated intravenous dose of 50 mg/kg/day in rabbits, there were no drug-related reproductive effects.

Intraperitoneal doses of 320 or 80 mg/kg/day acyclovir given to rats for 1 and 6 months, respectively, caused testicular atrophy. Testicular atrophy was persistent through the 4-week postdose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days post-dose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. Testicles were normal in dogs given 50 mg/kg/day, i.v. for one month.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rat (50 mg/kg/day, s.c.) or rabbit (50 mg/kg/day, s.c. and i.v.). There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in animal studies, the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Zovirax is administered to a nursing woman. In nursing mothers, consideration should be given to not using acyclovir treatment or discontinuing breastfeeding.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS — Short-Term Administration: The most frequent adverse reactions reported during clinical trials were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat.

Long-Term Administration: The most frequent adverse reactions reported in studies of daily therapy for 3 to 6 months were headache in 33 of 251 patients (13.1%), diarrhea in 22 of 251 (8.8%), nausea and/or vomiting in 20 of 251 (8.0%), vertigo in 9 of 251 (3.6%), and arthralgia in 9 of 251 (3.6%). Less frequent adverse reactions, each of which occurred in less than 3% of the 251 patients (see number of patients in parentheses), included skin rash (7), insomnia (4), fatigue (7), fever (4), palpitations (1), sore throat (2), superficial thrombophlebitis (1), muscle cramps (2), pars planitis (1), menstrual abnormality (4), acne (3), lymphadenopathy (2), irritability (1), accelerated hair loss (1), and depression (1).

DOSAGE AND ADMINISTRATION: Treatment of initial genital herpes: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 10 days (total 50 capsules).

Chronic suppressive therapy for recurrent disease: One 200 mg capsule 3 times daily for up to 6 months. Some patients may require more drug, up to one 200 mg capsule 5 times daily for up to 6 months.

Intermittent Therapy: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 5 days (total 25 capsules). Therapy should be initiated at the earliest sign or symptom (prodrome) of recurrence.

Patients With Acute or Chronic Renal Impairment: One 200 mg capsule every 12 hours is recommended for patients with creatinine clearance ≤ 10 ml/min/1.73 m².

HOW SUPPLIED: Zovirax Capsules (blue, opaque) containing 200 mg acyclovir and printed with "Wellcome ZOVIRAX 200" - Bottles of 100 (NDC-0081-0991-55) and unit dose pack of 100 (NDC-0081-0991-56).

Store at 15°-30°C (59°-86°F) and protect from light.

*In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.

Burroughs Wellcome Co., Research Triangle Park, North Carolina 27709



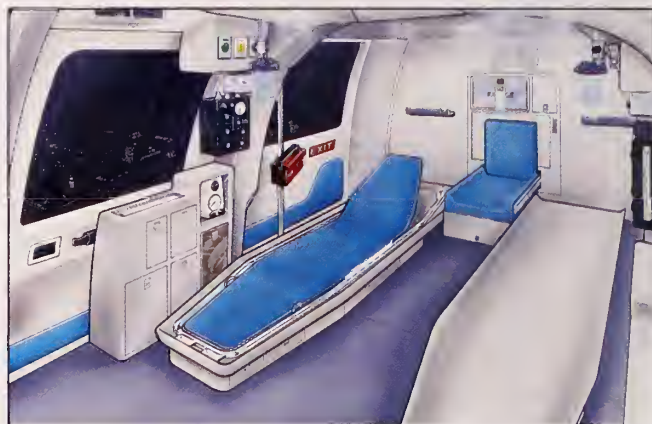
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Lessons in Deception

Two "reporting measures," one already in effect and the other in the final stages of consideration reveal, with almost chilling clarity, the thoughtless, misguided, and extravagant policies of the ruling bureaucracy currently in charge of physician-hospital defamation.

First, consider the publication and distribution of lists of physicians who have agreed to accept assignments as payments in full for their services. The suggested inferences are that such physicians represent common levels of competency, provide similar and equally satisfying services, and are not greedy, money-grabbing charlatans.

In truth, no such facts apply. The publishers and distributors of such lists make virtually no effort to determine the relative competency, practice patterns, or professionalism of any of the listed physicians.

In contrast to the invited inferences, the public should be advised that it is quite possible that many of the physicians who accept Medicare assignments have been forced to adjust their practice patterns in order to maintain fiscal solvency. This applies particularly to the primary care physicians who provide cognitive services and do none of the jackpot procedures so richly reimbursed by Medicare allowances. The adjustments essential to economic survival are most severe in the services that are the least rewarded by reimbursement schedules. Leading this category is time spent by physicians in patient contact; time spent obtaining complete medical histories; time spent performing thorough physical examinations; time spent explaining diagnoses and treatments to patients and their families; time spent maintaining accurate, detailed records; time spent studying current literature relevant to case management; time spent preparing reports, returning phone calls, writing prescriptions. For the physician who accepts Medicare assignments, time spent is income lost. Frequently, Medicare reimbursements in cases

requiring exceptional amounts of physicians' time will not even meet overhead expenses.

Lesson: Patients who need or want a physician who will spend time with them should *avoid* those who accept Medicare assignments.

A second example of bureaucratic deception is about to be "made available" to the public. This is the plan to publicize mortality rates for every hospital that receives Medicare funds. Here the invited inference is that the best hospitals are those with the lowest mortality rates.

This patent nonsense completely ignores many of the factors which influence hospital mortality rates. Hospitals that do not admit seriously ill or injured patients because there are no empty beds, or there are no specialists on the staff, or there are no special care units, or there is a grossly inadequate number of nurses available, or the hospital workers are on strike, or the surgical suites are closed because of excessive infection rates, will be able to boast about their low mortality rates.

Also, hospitals having staffs that tend to ignore "do not resuscitate" orders, that are too quick to employ respirators, defibrillators, total parenteral alimentation, and dialysis, irrespective of diagnoses, patients' conditions or prognoses, will enjoy low mortality rates. This is especially true when arrangements can be made to speedily discharge dying patients to their homes, to skilled care facilities, to hospices, to nursing homes, or to other "more appropriate" hospitals.

Lesson: Hospital mortality rates in general bear *no* relationship to the quality of care provided.

Some lessons cost more than others. The final figure on these is yet to be determined, but we can be sure it will be paid by patients, physicians, and hospitals, and not by those who refuse to see it is better to guide than deceive.

—MRJ

Oh! Say can you see?

Not in modern history has any single profession or segment of the population been singled out by national lawmakers for the oppression currently suffered by our profession.

Laws prohibiting the free exercise of contractual arrangements between free individuals in this society seem to be in direct conflict with the Constitution of this great country. Yet we hear no great outcry, except from physicians, and very little from our patients whose medical care is being compromised. Are there only certain populations that are entitled to due process and equal protection of the law under our Constitution?

Where are the physicians' and patients' civil rights?

BY THE DAWN'S EARLY LIGHT

Why is there no more outcry than there is? Are we so beaten that we no longer have the will to fight the battle? Are we so ashamed of our profession, have our fees been so high, that we are willing to take whatever the third party payor decides is fair? When all of our freedoms are gone, will we take a pittance for our talents, skill, and hard work — will we not fight?

We are not the only ones who are oppressed. The Medicare patients appear to be unaware of the



rationing of health care. In our efforts to be our patients' advocate, we are maligned by the media and accused of self-serving actions while politicians, who would use the plight of sick people to further their political ambitions, go unanswered.

WHAT SO PROUDLY WE HAILED

Is the greatest medical system in the world to perish because we will not mount an all-out fight to protect it and our patients? Are there no more heroes? No one with an "Impossible Dream"?

AT THE TWILIGHT'S LAST GLEAMING

I am firmly convinced that unless we can unify very, very soon, put our personal agendas aside, and become like the Three Musketeers — "all for one and one for all" — it is only a short time before we will no longer have any options.

THE ROCKETS' RED GLARE THE BOMBS BURSTING IN AIR

I invite your comments, solutions, or suggestions. Be my guest — write the President's Page.

W. J. Rosenthal, M.D.

Brachial Plexus Injuries

GHAZI M. RAYAN, MD

Brachial plexus injuries may occur at birth or later in life due to trauma. The etiology and pathology are variable. Diagnosing the level and extent of injury to the brachial plexus and predicting the prognosis in a patient with flail anesthetic arm can be a difficult task. The recent advances in microsurgical reconstruction have improved the methods for treating such injuries. However, when to treat and when not to treat such injuries is the challenging question for the physician dealing with such injuries.

In recent years, a rapid increase in the incidence of brachial plexus (BP) lesions due to industrial and traffic accidents has occurred. Motorcycles and modern machinery have increased the risk of trauma to the brachial plexus despite improved safety procedures and precautions. On the other hand, improved obstetrical procedures have brought about a decrease in BP palsies. The recent advances in microsurgical reconstruction have provided promising results and have diminished the need for and the level of amputation following certain BP injuries.

Anatomy

The brachial plexus takes origin from the anterior rami of the fifth to eighth cervical and first thoracic nerve roots. A prefixed plexus takes contribution from the C4 nerve root, whereas a postfixed plexus takes contribution from the T2 nerve root. The BP has five roots, three trunks, six divisions, three cords, and six major terminal branches. Roots and trunks are in the neck area, divisions are behind the clavicle, and cords and terminal branches are in the axilla. Roots and divisions are related to the subclavian artery, while cords are related to the first and second parts of the axillary artery. Cords become terminal branches at the lower border of the pectoralis minor muscle. The upper trunk is formed by the C5 and C6 nerve roots. The middle trunk is formed by the C7 nerve root, whereas the lower trunk is formed by the C8 and T1 nerve roots. Each trunk has anterior and posterior divisions. The three posterior divisions join to form the posterior cord. The anterior divisions of the upper and middle trunks unite to form the lateral cord, while the anterior division of the lower trunk continues alone as the medial cord.

Branches may arise from anywhere in the brachial plexus except from the divisions. Branches of the roots are the long thoracic nerve that supplies the serratus anterior muscle, and the dorsal scapular nerve that supplies the levator scapulae and

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rhomboid muscles. Branches from the trunks are the suprascapular nerve (upper trunk) supplying the supraspinatus and the infraspinatus muscles. Branches from the lateral cord are the lateral pectoral nerve, from the posterior cord are the upper and lower subscapular nerves which innervate the teres major and subscapularis muscles, and the thoracodorsal nerves which supply the latissimus dorsi muscles. Branches from the medial cord are the medial pectoral and the medial cutaneous nerves of the arm and the forearm. Every cord divides into two major branches. The lateral cord divides into the musculocutaneous nerve and the lateral root to the median nerve. The posterior cord divides into the radial and axillary nerves. The medial cord divides into the ulnar nerve and the medial root to the median nerve.

Classification

Traction, compression, and penetration are the three most common mechanisms of injury to the BP. Brachial plexus injuries may be partial or complete. Complete injuries imply involvement of all roots (C5-T1), all trunks, all cords, or a combination of these. The following classification of brachial plexus injuries as open or closed is adopted from Sunderland¹ with some modification.

Open Injuries. *Penetrating injuries* are due to missile or stab wounds. They may involve the supraclavicular or infraclavicular portions of the plexus. A concomitant injury to a vessel may lead to hematoma formation or later to a false aneurysm that may aggravate the symptoms and signs by creating compression neuropathy.

Iatrogenic injuries occur during diagnostic or surgical procedures. A common situation arises during axillary artery puncture for an arteriogram.² This may result in brachial plexus compression by the formation of a hematoma within the neurovascular sheath. Manifestations of nerve involvement will be evident within a few days and frequently within 24 hours. When nerve involvement is diagnosed, the brachial plexus should be explored without delay, the hematoma should be evacuated, and the leaking artery should be repaired.

Intra-operative stretch injuries have been reported during reconstruction of burn-injured axillae.³ Postoperative splinting in abduction can add to the insult. The splint should be removed promptly and therapy should be instituted.

BP injury with causalgia⁴ following transaxillary rib resection has been reported.

Closed Injuries. These may have a variety of causes including the following:

Direct Trauma. This may be due to (a) *athletic accidents* sustained while engaged in sports such as hockey and lacrosse; (b) *"firearm recoil palsy,"* which occurs when the firing of a rifle or shotgun forces the clavicle backwards, compressing the upper trunk of the brachial plexus against the underlying structures; or (c) *"rucksack paralysis,"* which is produced by direct pressure or prolonged unrelieved compression of the upper trunk of the brachial plexus by heavy, ill-fitting, or badly adjusted rucksacks or baby carriers.

Traction Lesions. The brachial plexus is triangular in shape, with a medially located base along the vertebral column and a lateral apex in the axilla. It is maintained in a taut condition by the weight of the dependent limb. Between these two points the plexus is not securely fixed, but is free to elongate when stretched during movements. During such movements the plexus is protected by the elasticity of the nerves, the plexiform structure of the fascicles, and the strength of the sheath attachment to the cervical nerve roots at the transverse processes.

The magnitude, direction, and rate of the deforming force are factors that affect the type and extent of traction injury. Traction on the arm downwards affects the upper plexus, while traction upwards, eg, during difficult breech or vertex delivery, affects the lower plexus.

Traction lesions are caused by sudden hyperabduction of the shoulder, as in a fall, or by sudden depression of the shoulder, as in a blow from a heavy falling object, or by displacement of the trunk on the fixed shoulder, as in a fall from a motorcycle. Most traction lesions are mixed lesions; some parts may suffer only first- or second-degree damage, but other parts may be subjected to third-degree damage. It is the severe stretch injuries with often unsatisfactory results that give traction lesions a bad reputation.

Special Lesions. (a) *Palsy with vascular injury and disease:* Vascular injury may lead to aneurysm or hematoma formation, with subsequent compression of the plexus. Hemophilic patients and patients taking anticoagulant medications are predisposed to bleeding within the plexus with relatively minimal trauma or from the improper use of crutches.

(b) *Palsy with fractures and dislocations:* The

plexus may be stretched, compressed, contused, or lacerated. A common example is shoulder dislocation where infraclavicular lesions occur at the posterior cord level; other cords may be involved. Clavicle or first rib fractures may be associated with or cause brachial plexus injury.

(c) *Post anesthetic palsy*: These injuries result from stretching or compression of the plexus during surgery while the muscles are relaxed. Stretching occurs when the head is extended and tilted to the opposite side as the arm is positioned in extreme abduction and external rotation, and occasionally occurs when the patient is in the sitting position.⁵ Compression occurs in abduction and external rotation of the shoulder by the humeral head and by narrowing of the costoclavicular space or as a result of incorrectly applied padding.

Parks⁶ analyzed 50,000 operative procedures and found open heart surgery to be the most common

cause of postanesthetic BP palsy. The upper plexus was more involved than the lower plexus, and motor loss was more evident than sensory loss. The shortest operative time that caused palsy was two hours, and the majority of palsies were first-degree lesions that recovered spontaneously. Sefyer et al⁷ found that following cardiac surgery, the predisposing factors for BP palsy are wide retraction of the sternum (because of its dorsal articulation, the first rib can only move upwards as the sternum is retracted) and extended cardiopulmonary pump support.

Chronic Lesions. These are due to intermittent or continuous compression, traction, or friction. Among the causes of chronic irritation of the plexus are (a) bony overgrowth, such as cervical spondylosis or cervical disc; (b) compression by enlarging aneurysm or space-occupying lesion such as a Pancoast tumor; (c) clavicular malunion or excessive callous formation following fractures of the clavicle



Figure 1 A. Eleven-month-old child with right Erb's palsy without evidence of clinical or electrodiagnostic recovery. The patient is unable to actively abduct, externally rotate the shoulder, and unable to flex the elbow, supinate the forearm, or extend the wrist. **B.** The child at

three-and-a-half years following exploration of the brachial plexus with sural nerve grafting of C5 and C6 nerve roots and neurolysis of C7 nerve root. Active shoulder and elbow motion was restored. Wrist extension was not strong and required tendon transfers.

or the first rib; (d) thoracic outlet syndromes, which often involve the lower plexus;⁸ (e) Risser hyperextension casting, which may produce injury due to traction;⁹ and (f) irradiation plexitis occurring following radiation directed to the supraclavicular region of the plexus, as in the treatment of breast cancer. External neurolysis to decompress the plexus along with free vascularized omentum flap has been recommended as effective treatment for such lesions.¹⁰

Birth Palsy. Damage to the brachial plexus during difficult delivery has been recognized for more than two centuries. Although traction is the most common cause of birth palsy, compression between the clavicle and the first rib may be a causative mechanism. The plexus is susceptible to injury during difficult breech or vertex delivery. Traction on the head and neck to free the anterior shoulder places traction on the upper plexus, leading to C5-C6 injury (Erb's palsy). In breech delivery, the upper or lower roots can be involved depending on the position of the arm. Traction on the lower plexus leads to C8-T1 injury (Klumpke palsy). A commonly injured area is at or above the coalition of C5 and C6 nerve roots (Erb's point). The characteristic posture of the limb in Erb's palsy is shoulder internal rotation, elbow extension, forearm pronation, wrist and finger flexion ("policeman's" or "waiter's tip" position).

Brachial plexus birth palsy with flaccid paralysis of the limb should be differentiated from cervical spine injury, cerebral palsy, and arthrogryposis. Associated fractures of the clavicle, humeral epiphysis, and cervical spine may occur.

The prognosis is difficult to predict in these patients because of the uncertainty surrounding the extent and severity of the damage. Electromyography is advocated in these cases to confirm the clinical diagnosis, to evaluate the nature and extent of the lesion, and to follow the course of recovery, although it is a difficult test to do in neonates.

Recovery is influenced by the severity of injury. First-degree damage is reflected by improvement in a few weeks, and recovery is complete in a few months. Second-degree injury will delay the recovery for several months. Root avulsion was reported to occur in 17% of the cases, but in spite of this, recovery of the limbs affected with root avulsion was excellent in contrast to similar lesions in the adult.¹¹

In general, more than 80% of the cases will recover spontaneously. In children who do not recover spontaneously, microsurgical reconstruction of the plexus^{12,13} may offer satisfactory results (Fig 1). Late

deformities following birth palsy may affect the shoulder in the form of adduction, internal rotation, and flexion, which may lead to posterior dislocation. Late elbow deformity may be in the form of flexion contracture¹⁴ or posterior or, less often, anterior dislocation of the radial head.¹⁵ Lastly, posterior or, less often, anterior dislocation of the elbow may occur.¹⁶

Diagnosis

Determining the level and severity of the lesion is sometimes difficult, but should be the main objective of evaluation. The clinical picture and certain diagnostic tests can help in reaching that objective.

History and Physical Examination. Traction injury is often extensive and has a worse prognosis than compression injury or even penetrating injury. Nerve root involvement should be suspected when severe traction lesions are associated with head or cervical spine injuries. The position of the limb in relation to the neck and trunk indicates the location of the lesion. Distressing and incapacitating pain in an insensitive limb, ie, causalgia, suggests nerve root avulsion.

Neurological examination reveals the distribution of the motor and sensory deficit. Tinel sign will signal the presence and permit tracking of the advance of regenerating sensory fibers. Horner's syndrome points to the involvement of C8 and T1 nerve roots, and indicates that sympathetic innervation to the upper extremity has been interrupted.

Paralysis of certain muscles indicates the level of injury. For example, paralysis of the diaphragm, levator scapulae, and rhomboid muscles suggests injury to higher root level (C5, C6). The clinical evaluation was found to be the most reliable form of assessment of the type (pre- or postganglionic) and nature (continuity or rupture) of plexus lesion.¹⁷

Electrodiagnostic Testing. *Sensory Nerve Conduction Studies.* Sensory action potentials offer an objective method of evaluating levels of injury. The presence of sensory nerve fibers serving an anesthetic area and continuing to conduct sensory action potentials points to a lesion of the posterior nerve root between the ganglion and the cord (preganglionic). On the other hand, the loss of action potentials indicates a lesion distal to the ganglion (postganglionic).

The comparison of a somatosensory-evoked-

potentials recording from the cervical spine or sensory cortex (in response to stimulation of peripheral nerves) with the amplitudes of normal-side responses can be helpful, especially in diagnosing incomplete plexus lesions.^{18,19}

Motor Nerve Conduction Studies. These may be helpful as early as three to five days following injury. If motor conduction across the lesion is absent but motor nerve fibers continue to respond to electrical stimulation below the lesion, then these fibers have suffered only first-degree damage and will recover spontaneously. If motor conduction is absent below the lesion, then the nerve fibers are undergoing wallerian degeneration, which indicates a higher degree injury (2 to 5 degrees).

Electromyography is of great value in outlining the extent of motor loss in a degenerative lesion and in defining the residual areas of permanent motor loss. However, following degeneration of motor fibers,

muscle action potentials are replaced by fibrillation potentials, which can be detected two to three weeks after injury. The status of the serratus anterior muscle, which is innervated directly from three spinal nerves (C5-C7), can be determined electromyographically. This information provides a clue to the level of the lesion. Also, the dorsal cervical paravertebral muscles are innervated by the posterior rami of the cervical spinal nerves as they emerge from the intravertebral foramen. The presence of fibrillation potentials three weeks after injury indicates damage to the spinal nerves at that level.

X-Ray Examination. Fracture of the transverse processes of the cervical spine may present with nerve root damage. Fractures or dislocations involving the glenohumeral and sternoclavicular joints may present with BP palsy at the division



Figure 2 A. Eighteen-year-old who sustained traction injury to the brachial plexus 9 months earlier when hit by a car and thrown off his bicycle. There was no evidence of clinical or electrodiagnostic recovery. Active shoulder and elbow flexion were absent. **B.** Eighteen

months following exploration and sural nerve grafting of a severe traction lesion at the cord level. The patient recovered active elbow flexion.

level. Paralysis of the diaphragm indicates damage of the phrenic nerve (C3-C5) and should be suspected when severe stretch lesions of the plexus are accompanied by respiratory symptoms.

Myelography. Nerve roots may be avulsed without disturbing the anatomy of the intervertebral foramen so that the lesion is not accompanied by myelographic changes. However, nerve root avulsion usually produces pathologic changes at the foramen that modify the normally symmetrical indented lateral contour of the dura, with the formation of meningeal diverticulum. The clinical findings and those provided by myelography and direct inspection of the nerve root intra-operatively are not always compatible. As previously noted, avulsion may be present in the absence of myelographic changes; on the other hand, the dura may be torn and the diverticula develop without avulsion or with only partial avulsion of the corresponding nerve root. Myelography does not enjoy absolute reliability in revealing nerve root avulsion; however, it still remains a useful diagnostic aid.

Axon Reflex Testing. Axon reflex testing provides supplementary aid in the investigation of suspected nerve root avulsion. The *histamine flare response* is elicited following intradermal injection of a 1% solution of histamine acid phosphate. The reflex is absent due to lesion that is distal to the ganglion. Failure to elicit the response means that the nerve

vasodilation five to ten minutes later. This reaction is absent in postganglionic lesions, but retained in lesions proximal to the ganglion.

MRI. The role of magnetic resonance imaging (MRI) as a diagnostic tool for peripheral nerve and brachial plexus injuries is still under investigation. It may prove to be of value as more experience is gained.

Prognosis

The prognosis of brachial plexus injuries depends on the degree, level, and mechanisms of injury. Sunderland¹ classified peripheral nerve injuries into five degrees. First degree is the most benign and fifth degree is the most severe. The lower the degree of nerve injury, the better the prognosis for spontaneous recovery. A lesion of the first or second degree has a good chance of spontaneous recovery. Occasionally, a lesion of the third degree may recover spontaneously, but only after a long time.

Millesi²⁰ classified BP lesions according to the level of injury: *Level I* — supraganglionic lesions of the root. The roots are avulsed from the cord. Sensory fibers do not degenerate, a neuroma does not form, and Tinel's sign is absent. *Level II* — infraganglionic lesions of the root. Both sensory and motor fibers degenerate, neuroma forms, and Tinel's sign is present. *Level III* — lesions of the trunk. The levator scapulae, rhomboids, and serratus anterior muscles are spared. *Level IV* — injuries at the cord level may be supraclavicular, infraclavicular, or both.

Compression injuries have a better prognosis than traction injuries. Closed infraclavicular lesions associated with shoulder joint injuries have a good prognosis, and complete spontaneous recovery occurs often. Even traction lesions with mild degrees of involvement, such as the postanesthetic group, are transient injuries, and recovery usually occurs within a few weeks. Upper plexus lesions (C5 and C6), such as upper trunk, lateral, and posterior cord, have a better prognosis for spontaneous recovery and recovery after nerve surgery and reconstruction than do lower plexus lesions such as lower trunk and medial cord (C8-T1). Nerve root avulsions carry a very poor prognosis. The presence of Horner syndrome, paralysis of rhomboids, levator scapulae, serratus anterior, and the diaphragm muscles, indicates root damage and probably avulsion of the nerve roots from the spinal cord and, therefore, implies a poor prognosis.

Compression injuries have a better prognosis than traction injuries.

fibers innervating the area have been divided distal to the ganglion, whereas the appearance of the flare response in an insensitive limb indicates that the lesion is proximal to the ganglion. This test should be done a few weeks following injury.

The *cold vasodilatation test* is performed by the thermoelectric measurement of heat loss from a fingertip immersed in 2°C-to-5°C water. Normally, rapid cooling is expected, followed by reactive

Pain may be distressing, especially in patients with complete preganglionic lesions. The majority of these patients have pain at some stage of their injury. If the pain does not improve within three years after injury, it is most likely to persist throughout the patient's life.²¹ Neurosurgical destruction of the dorsal root entry zone may offer pain relief.

Excluding root avulsions, most closed lesions recover spontaneously with conservative treatment. Approximately 30% will not recover and will require surgery. In second-degree injury, signs of recovery are usually delayed 4 to 6 months for shoulder muscles, 6 to 12 months for arm muscles, 12 to 15 months for forearm muscles, and 18 to 24 months for the intrinsic muscles of the hand. In the case of severe injury, only the passage of time will separate the recoverable from the irreparable.¹ Some recovery may occur in shoulder muscles after a delay of 12 months or more. Usually recovery of function distal to the forearm is negligible.

Treatment

Because patients with brachial plexus lesions are often severely injured, associated serious injuries may be present.^{22,23} Once the diagnosis is made, priority of treatment should be established and the life-threatening injuries should be given attention first.

Nonoperative treatment consists of therapy to prevent joint stiffness and soft tissue contracture. Splinting is occasionally required to prevent contractures and to optimize limb function.²¹ Non-operative treatment also includes prosthetic fitting and rehabilitation if amputation is indicated. Galvanic and Faradic electrotherapy of the muscles can be employed. Transcutaneous nerve stimulation may be beneficial for relieving pain. The patient should have repeated motor (manual muscle testing) and sensory evaluations to assess the progress of recovery. Patients with no chance of recovery, such as those with supraganglionic lesions or long-standing injuries, are not candidates for exploration of the plexus.

Operative treatment consists of the following: (1) exploration and neurolysis in the presence of intact plexus with second- or third-degree injury and external compression due to excessive scarring; (2) primary or delayed primary repair of the components of the plexus in cases of sharp laceration; (3) nerve grafting for fourth- or fifth-degree injury when segmental damage is present; and lastly, (4)

neurotization or nerve transfer in case of nerve root avulsion (preganglionic lesion) of the upper plexus.^{24,25}

Open Injuries. Brachial plexus injuries due to stab wounds and wounds caused by sharp penetrating objects offer a prospect for direct repair. These should be explored early and treated in the same manner as peripheral nerve injuries.²⁶ High-velocity-missile wounds and lesions due to gunshot wounds should be treated conservatively at first because some of these may spontaneously recover. Rarely, there are cases of localized damage where the conditions are favorable for some sort of repair.²⁷

Closed Injuries. Treatment of closed brachial plexus injuries, especially traction lesions, poses a problem to the patient and the surgeon. Surgical exploration of these injuries is thought by some to be unnecessary. More recently, however, exploration of BP traction injuries (except preganglionic lesions) has become a common practice in many centers because of the encouraging results following nerve reconstruction.^{12,13,20,28,29}

Exploration of the plexus is indicated when spontaneous recovery does not occur or is incomplete. Early exploration has been advocated by some, but exploration is best delayed three to four months until evidence of recovery is ruled out both clinically and by electrodiagnostic tests. During this time, the patient should be examined at frequent intervals. Sometimes, in first-degree injuries, the onset of recovery is delayed for as much as eight weeks. Sunderland believed that procedures on stretch lesions should be carried out no later than three to four months after injury occurs because after this period of time a first-degree injury will be excluded. He emphasized that the prospects of obtaining useful recovery in the hand following repair of the lower plexus have in the past been poor. Therefore, any attempt to repair these particular lesions is probably a fruitless exercise.

Nerve grafting is utilized often following exploration of traction lesions. Generally, the lateral and posterior cords are the favorite recipients and the sural nerve is the preferred donor nerve. The basic procedure is for the fifth cervical stump to be anastomosed to the lateral cord. In the presence of two stumps, the fifth is anastomosed to the lateral cord and the sixth to the posterior cord. An irreparably damaged plexus can sometimes appear normal intra-operatively because the neuromas that develop

at the site of rupture merge with the enveloping scar tissue and the interlacing bundles of the plexus.

Nerve root avulsions (preganglionic lesions) are best treated conservatively in the first instance until spontaneous recovery can be clearly defined. Neurotization or innervating the plexus (particularly the lateral cord or musculocutaneous nerve) by the intercostal nerves, using nerve grafts to bridge the gap, has been described. Also, transferring the accessory nerve to the musculocutaneous nerve has been done. Brunelli used spinal accessory and other nerves of the cervical plexus, such as nerves to the trapezius, levator scapulae, sternocleidomastoid, and rhomboid muscles.

These complicated reconstructive procedures are now being undertaken in increasing numbers; however, they are still in an experimental phase in spite of experiences accumulated over several years. In some situations, nerve transfers are rewarding when used to restore one simple function at a time, such as elbow flexion or extension, but they are disappointing when restoration of complex function is expected.

Reconstruction for Irreparable BP Injuries.

This is an option when spontaneous recovery is impossible or nerve surgery is not indicated. This includes the various reconstructive procedures performed on the shoulder, elbow, wrist, and hand.^{30,31} These include arthrodesis, such as that of the shoulder and wrist. Tendon transfers can be used to restore active motion to the shoulder, elbow, and hand. Tendon transfers to restore hand function can be used with wrist arthrodesis, where wrist flexors and extensors can be utilized as motors. Tendon release, such as in the shoulder area, and osteotomy of the proximal humerus are less common procedures.

Amputation. Above-elbow amputation is considered for the symptomatic flail anesthetic arm that is complicated by chronic infections and multiple fractures or nonunion. Amputation should be advised after suitable counseling. Shoulder arthrodesis following amputation is recommended for the true prosthetic user.³²

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Extracorporeal Shock Wave Lithotripsy in Oklahoma

DAVID L. HARPER, MD

In August of 1986, the first patient in Oklahoma was treated with extracorporeal shock wave lithotripsy (ESWL) at St. John Medical Center in Tulsa. Herein is a summary of the procedure and the first 179 cases treated.

Kidney stone disease is very common in the United States and especially in the southern regions. It is estimated that 5,000 patients in Oklahoma are hospitalized each year for kidney stone disease, and approximately 40% of these will undergo an endoscopic or surgical procedure for stone removal. These figures do not include the large numbers of patients with stone disease who are not hospitalized. ESWL is adaptable to the treatment of most kidney and upper ureteral calculi. It is estimated that at least 1,000 patients per year in Oklahoma should be candidates for treatment with ESWL.¹

Shock wave lithotripsy is a noninvasive technique using shock waves to effect the disintegration of stones. It was developed in West Germany and the first human was treated successfully in 1980 by Dr Christian Chaussy.^{2,3} The equipment costs about two million dollars to install, and at present there

are over 120 lithotripters in the United States. Over 300,000 patients have been treated worldwide since 1980.

Methods

Under general or regional anesthesia, the patient is lowered into a water bath containing a shock wave generator (Fig 1). The high energy shock waves, which are triggered by the patient's heartbeat, can be transmitted through water and focused to strike the stone at the focal point of the wave. The shock waves disintegrate the stone, and the fragments subsequently pass down the ureter. Fluoroscopic monitoring ensures that the stone is maintained at the proper focal point for treatment as the procedure progresses. The entire procedure takes less than one hour, and most patients receive less than 2,000 total shocks.³⁻⁵

Patients selection is important, and solitary stones less than 2.0 centimeters in diameter yield the best results, with a single treatment being successful in 90% to 95% of cases. Multiple stones and stones greater than 3.0 centimeters in diameter may require ancillary procedures such as percutaneous lithotripsy to first debulk the stone, or may later require a second ESWL treatment. Ureteral stones may require manipulation or passage of a ureteral catheter to make ESWL more effective.

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Patients may be divided into Category A and Category B Classifications. Those in Category A are characterized by the following:

1. Solitary, densely opaque pyelocaliceal stone
2. Stone less than 2 centimeters in diameter
3. Sterile urine
4. Absence of obstruction distal to stone
5. Normal body habitus
6. Creatinine less than 3.0 mg %
7. Absence of significant aortic or renal artery calcification.

Category A patients are excellent risks for ESWL therapy and a success rate greater than or equal to 90% would be expected.

Patients in Category B are characterized by the following:

1. Multiple pyelocaliceal stones
2. Stones greater than 2 centimeters in diameter
3. Upper ureteral stones
4. Radiolucent stones
5. Infected stones

Category B patients may be good candidates for ESWL, but the complication rate is slightly higher and the retained stone fragment rate might approach 25% to 35% in some cases.^{1,6}

Present contraindications to ESWL therapy include most cardiac pacemaker patients, pregnancy, bleeding disorders, renal artery calcification, ureteral obstruction below the level of the stone, patient weight over 300 pounds, and extremes of height (over 6'8" and under 48"), although adaptations have been made. Lower ureteral calculi cannot be treated unless they first can be manipulated into the upper ureter or renal pelvis. There are other relative contraindications to therapy that should be assessed on an individual basis.

Secondary procedures have been performed in 10% to 50% of patients in previous studies, but are becoming more common with the treatment now including multiple stones and larger stones.^{1,4-6}

Cystoscopy with the insertion of a JJ ureteral stent has become one of the standard treatments in the United States and most physicians who use it feel that the stent decreases post-treatment morbidity, especially of patients with larger stone burdens. The JJ stents dilate the ureter and the disintegrated particles pass around it with less chance of ureteral obstruction. The stents can be removed one to three weeks post-ESWL, usually in the office.

Complications from ESWL rarely occur. They include pain and obstruction of the ureter, perirenal

hematoma, and persistent hematuria. Occasional secondary procedures post-ESWL, such as a temporary percutaneous nephrostomy, cystoscopy with stone manipulation, or passage of ureteral catheters, may be necessary due to obstruction. Fewer than one in 1,000 patients have died within two months post-ESWL, and most deaths apparently were not associated with treatment. There have been a few deaths associated with heart disease or hypertension and any relationship with the treatment is not known. Five deaths associated with ESWL were reported to the FDA in the first 50,000 patients treated in the United States.⁷

Results

One hundred seventy-nine patients were treated with ESWL at St. John Medical Center during the first three months of operation. Of these, 23% were treated as outpatients. The average length of hospitalization for inpatients was 2.3 days. Of those treated, 67% were male and 33% female, and the age range was: 0-18 years (2%), 19-44 years (38%), 45-64 years (36%), and 65 years or older (24%). General anesthesia was used 100% of the time, although regional anesthesia with epidural block is an acceptable alternative. The average number of shocks was 1,800 per patient, and the average tub time per patient was 45 minutes. Seventy percent of patients underwent an ancillary procedure, the majority being cystoscopy and insertion of a ureteral catheter or JJ ureteral stent. These were employed to help localize the stone, to manipulate the stone into a better position for treatment, or to dilate the ureter to promote passage of disintegrated stone fragments. Six percent of outpatients required admission within 48 hours after treatment for either pain, hematuria, or fever, and 2.25% (4 patients) of all patients treated required two or more ESWL treatments in the first three months.

Preliminary results on followup have been similar to most published results in large series. The overall stone-free rate at three months has been 75% to 80%. Some residual stone fragments, which are asymptomatic, have been found in 15% to 20% of the patients, and fewer than 4% had no significant disintegration of stones by ESWL.

(As of May 1987, over 330 patients have been treated with ESWL at St. John Medical Center. More than 60% of the last 150 patients were treated as outpatients. Followup figures have shown 85% of patients to be stone-free post-treatment, 13% are

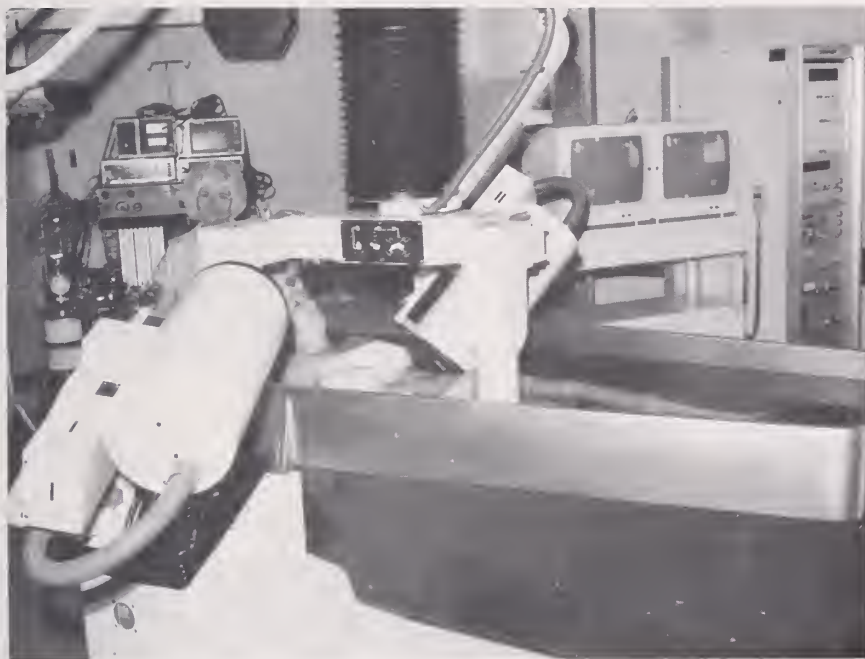


Figure 1. Patient lowered into tub for shock wave lithotripsy.

asymptomatic with some residual stone fragments, and 2% had unsuccessful treatments. Ten percent of patients have required post-ESWL secondary procedures such as cystoscopy, stone manipulation, temporary percutaneous nephrostomy, or secondary ESWL before they were completely rid of the stone fragments.)

Discussion

Extracorporeal shock wave lithotripsy is a remarkable new form of treatment of kidney and upper ureteral stone disease. Most healthy patients with small (less than 2 centimeters in diameter) stones can be treated in an outpatient setting. Almost all patients treated in the hospital are discharged by the second day post-treatment. As more experience is obtained, more patients are being treated as outpatients and hospital stays are getting shorter. Most studies have shown success rates in the range of 90%, but when all types of kidney and upper ureteral stones are treated, 25% to 30% of patients may have some residual asymptomatic stone fragments after three months.

As with standard surgical treatment of urinary stone disease, clinical judgment is very important in selecting appropriate patients for therapy with ESWL. Not all patients with stones are good candidates for lithotripsy, and evaluation by a

urologist familiar with ESWL is certainly recommended before scheduling a patient for the procedure. ESWL is no more costly than conventional open surgery and definitely is advantageous in returning patients to a normal life in an expeditious fashion with little morbidity. □

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AIDS and Atoms

Story and Photographs by Robert C. Hardy

On May 18, Edward N. Brandt, Jr., MD, chancellor of the University of Maryland at Baltimore, former US Assistant Secretary for Health, and associate dean of the OU College of Medicine in the late 1960s, returned to the Oklahoma Health Center campus to lecture about AIDS.

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Eleven days later, International Physicians for the Prevention of Nuclear War (IPPNW) began its Seventh World Congress in Moscow.

These medical problems, AIDS and nuclear war, are similar in that each has the distinct potential of becoming wildly epidemic. Each infected body, whether one human being or the entire planet, is at extremely high risk of dying should either disease manifest itself.



The Seventh World Congress of International Physicians for the Prevention of Nuclear War convenes in the Moscow Sports Arena.

At present, the prognosis is guarded because there is no cure for either malady — only prevention.

Education is the key to prevention, but people can become victims of these diseases through no fault of their own. Everyone is at risk to some degree.

The incubation period of AIDS is long — three to five years. The incubation period of nuclear war is unknown. Thus far it has lasted 42 years, since 1945 and Hiroshima, with an ever-increasing titre of infection now totaling 60,000 nuclear weapons.

Ed Brandt was highly optimistic about the probability of developing drugs that will arrest AIDS and a vaccine that will prevent it. To identify the virus which causes AIDS in only three years of feverish research work was a remarkable achievement. He believes the rapidly expanding AIDS epidemic can be brought under control sooner than many expect. Indeed, medical science is becoming increasingly effective in conquering diseases worldwide. Just ten years after a global effort was launched to eradicate smallpox, this dreaded disease is no more.

It is not necessary to recite AIDS statistics and projections because medical journals and the lay press are full of such information. The flow of AIDS patients into American hospitals increases by the day.

In contrast, because there are no patients from nuclear war, some physicians tend to ignore this potentially greater medical problem. The casualties

resulting from a nuclear exchange would be so sudden, so numerous, and so severe as to be incomprehensible.

At the Moscow meeting, astronomer Carl Sagan said global civilization is endangered by the mass of nuclear weapons which now infects the planet. The US and the Soviet Union alone have 50,000 warheads aimed at 3,000 cities of 100,000 or more people. Counting which country has more of the 93 different kinds of warheads becomes a useless game. Land-, sea-, and air-based delivery systems differ, and the yield-to-weight ratio has increased dramatically. The bomb dropped on Hiroshima weighed five metric tons. A modern nuclear bomb with ten warheads, each having three times the power of Hiroshima, is contained in a one-ton package. Most nonstrategic nuclear devices, ie, tactical battlefield weapons, are smaller than a suitcase. What's more, there is decreasing need for high tonnage bombs because two small bombs have more destructive power than one large bomb of equivalent tonnage. The nuclear arsenals of the world are equivalent to three and a half tons of TNT for every human being on the planet.

Sagan estimated an "essential exchange" would kill outright hundreds of millions of people — up to two billion. Several billion more, he said, would die of starvation later because of "nuclear winter," where the smoke and dust cast into the atmosphere blocks heat and light from the sun, lowers the temperature of the earth, and markedly curtails food production.

He did not mention additional deaths from radiation sickness.

"We must rise to a new level of responsibility if mankind is to survive," Sagan insisted. We can no longer rely completely on technology; both Chernobyl and Challenger were spectacular failures. Neither can we rely completely on our leaders; madmen like Hitler and Stalin can reach the highest political office. As John F. Kennedy once said, "Nuclear war could begin by mistake, miscalculation, or madness."

The bomb has become the common enemy.

There is no longer a local solution to the containment of nuclear weapons and their abolition. They're everywhere! The original nuclear club had five members: US, USSR, Great Britain, France, and China. These countries also have missiles deployed in some 3,000 foreign military bases.

The nuclear nonproliferation treaty signed in 1964 has limited the spread of weapons — but not completely. Israel is known to have nuclear weapons; South Africa may have tested a bomb. Other countries suspected of possessing the ability and perhaps the inclination to build nuclear weapons include Iraq, Iran, Libya, India, Argentina, and Pakistan.

Evgueni Chazov, MD, a Moscow cardiologist and

cofounder of IPPNW, is now the Soviet Minister of Health. He agreed with Einstein that "We shall require a substantially new manner of thinking if mankind is to survive." He said, "The concept of nuclear deterrence makes mankind hostage to the equivalent of 6,000 World War II's. It is no longer possible to win the arms race or a nuclear war. Nuclear disarmament is necessary to rid the world of the threat of disaster. The security of one country cannot be built at the expense of another."

Dr Chazov recommended the establishment of a climate of trust between the two superpowers, with physicians leading the way. This process is already under way with 80,000 IPPNW members in the USSR and 30,000 in the US. The remaining 40,000 members are scattered throughout the world. Three thousand physicians attended the congress in Moscow, including psychiatrist Joel McKinney from McAlester, Okla.

Chazov further suggested that the \$1 trillion now spent each year on arms be used to improve the health of people. "The USSR," he said, "is at a crossroad and in a revolution of openness and cooperation."

Bernard Lown, MD, cardiologist at the Harvard School of Public Health, the other IPPNW founder

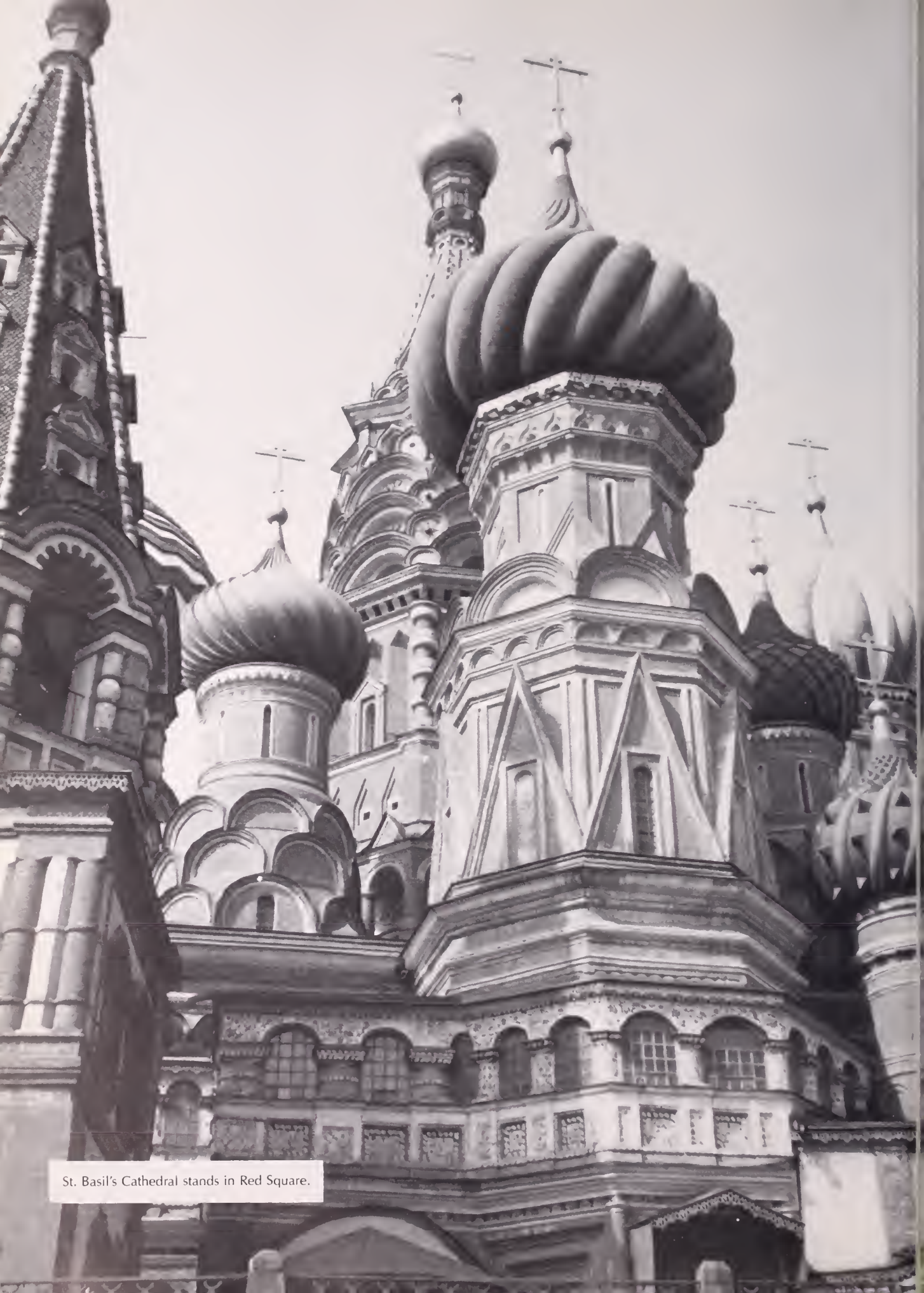
The first-time visitor to Russia hardly knows what to expect. The Stalin-era history of the USSR easily substantiates the "evil empire" label, but Gorbachev's Russia is radically different. Described by Martin Walker, a British correspondent, in his book *The Waking Giant* (Pantheon, 1986), the USSR is in a "transitional moment." Walker said, "The sense of energy and change and possibility I felt surging in the country (since 1984) has now been matched by a similar energy and purpose at the top."

Certainly, *glasnost* or openness proclaimed by Gorbachev appears to be real. IPPNW doctors visiting Moscow hospitals were accompanied by Soviet television crews. The plenary sessions of the congress were covered by television. A two-hour musical concert, presented especially for IPPNW visitors, was broadcast live and in its entirety. In Yalta, after the congress, five IPPNW physicians from

Panama, India, Australia, Britain, and the USA, were interviewed. Their pictures and opinions appeared on the front page of the Yalta newspaper under the headline Doctors Heard Throughout the Planet.

That was on the official level. On the people-to-people level, the Russians we met were friendly, kind, accommodating. Tourism is big business in the USSR, handled by a central bureau, Intourist. The system is computerless, slow, bureaucratic, and not very flexible. Nevertheless, one of our party managed to change her itinerary to include a two-day visit to Leningrad. Moreover, at the group's request, Intourist arranged an extra day at Yalta and a return flight to Moscow rather than adhere to the originally scheduled, 26-hour train trip. This was not a simple change because it involved forty visitors in the midst of the Russian vacation season when planes and hotels are booked in advance.

(continued)



St. Basil's Cathedral stands in Red Square.

and corecipient of the 1985 Nobel Peace Prize, said that International Physicians for the Prevention of Nuclear War advocates complete abolition of nuclear weapons. There is no conceivable circumstance which would warrant their use. At the same time, IPPNW recognizes this lofty goal cannot be achieved overnight. There must be practical, down-to-earth steps in this direction.

He said the first positive step should be a comprehensive nuclear test ban treaty. This would stop the arms race in its tracks because only new model weapons need be tested. Without testing, nations could not perfect more destructive weapons. Seismic technology now permits nuclear explosions as small as one kiloton to be differentiated from earthquakes, so the comprehensive ban would be verifiable.

Dr Lown listed IPPNW's priorities, preventive action in which every physician can participate:

1. Educate people to support the proposed comprehensive nuclear test ban treaty.
2. Stop the arms race on earth and in space.
3. Arrest the deterioration of the *quality* of life caused by the militarization of life.
4. Foster citizen diplomacy.
5. Promote medical cooperation on earth and in space.

The Russian people responded warmly as various situations brought us into contact. Twice, men gave their seats on the Yalta public bus to my wife, Ann. At the ballet, in the 100-year-old Odessa opera house, Ann and I shared a box with a beribboned Soviet war veteran/party member and his wife. We knew no Russian, they could not speak English; but we smiled, gestured, applauded, nodded, and got along famously.

Sitting in Yalta's Lenin Square at dusk on a Saturday night wasn't so different from attending a summer evening concert at Kerr Park in Oklahoma City. A statue of Lenin stood facing the Black Sea, its back to the Crimean Mountains. We watched families strolling in the colorfully landscaped park, parents taking their kids to ride a carousel, people resting on benches and eating ice cream, crowds milling about the entrance to a movie house, queuing

Because physicians are teachers as well as healers and have the trust and confidence of many persons, they are in a unique position to educate everyone about this medical problem, the threat of nuclear war.

Mikhail Gorbachev, in a written message to delegates of the congress, said:

Our country has declared for the elimination of nuclear arms. At any moment the Soviet Union is prepared to resume the moratorium on nuclear tests and ban them altogether if the USA as well as the other nuclear powers accept this. A peace built on deterrence with the help of nuclear weapons is a precarious and dangerous one. To try to strengthen it dependably through an ever new escalation of armaments, whether on earth or in space, means to advance in a direction contrary to the interests of peace.

The present-day situation is a historical challenge to political leaders and every individual. It serves as a reminder of responsibility. We deem it necessary to go over from competition in stockpiling the arsenals of destruction to cooperation in their radical reduction. The Soviet Union is prepared to honestly go its part of the way. While in possession of nuclear weapons, our state will never be the first to use them. The USSR solemnly declares that it is ready to renounce them completely before the year 2000 or earlier on the basis, of course, of reciprocity and under

up for a bus, enjoying the cool sea air. Children, families, and the simple pleasures of life are pretty much the same everywhere.

In each city, IPPNW members were invited to visit medical institutions. In Moscow, we toured the A.V. Vishnevsky Institute of Surgery. The director, M.I. Kuzin, MD, was president of the Seventh World Congress, replacing Dr Chazov as copresident of the IPPNW Executive Committee. In 1988, the congress will be in Montreal. The Ninth Congress is planned for Hiroshima.

In Odessa, we visited the Filatov Ophthalmological Institute, where doctors presented several patients and described the surgical procedures they use. The outpatient clinic we toured in Yalta was primarily a physical therapy center specializing in treatment of nontubercular lung problems.

— Robert C. Hardy

the most rigid international control. We are convinced the first steps toward nuclear disarmament can and must be made without delay.

The name Armand Hammer, chairman of Occidental Petroleum, is a household word in Russia, although many do not know he is a physician. He admits he "practices business" rather than medicine. He has known every General Secretary since Stalin and is well acquainted with Mikhail Gorbachev and Ronald Reagan.

During the opening session of the congress, the 89-year-old Hammer strode energetically across the stage of the Moscow Sports Arena to receive the IPPNW Humanitarian Award. A man with positive convictions, he forecast US-USSR relations, saying that at Geneva, Gorbachev and Reagan established a feeling of trust because the people of both countries want peace. They were close to agreement at Reykjavik, he continued, but elimination of the United States's Strategic Defense Initiative (Star Wars) had to be part of the package to satisfy the Soviets.

Now that SDI is separated from intermediate range missile (IMF) negotiations, Armand Hammer believes there will be a summit meeting of the two leaders in Washington in 1987, during which Gorbachev will address a joint session of Congress. The reasons are persuasive. Gorbachev wants to increase the standard of living of the Soviet people. Reagan wants to go down in history as a great president.

Hammer further predicted that after the intermediate and short-range missile reduction agreement, the next agreement will reduce strategic weapons by 50 percent. Eventually, perhaps by the year 2000 as Gorbachev proposed, all nuclear weapons will be abolished. Because both leaders are on record advocating total abolition, Dr Hammer's forecast may just be correct.

"But there is a catch," some protest. "You can't eliminate the *knowledge* of how to build the bomb!" To be sure, there is no way to get that genie back in the bottle but, as one delegate pointed out, "This knowledge has an enormous potential to reduce *conventional* weapons by threatening or actually reintroducing nuclear weapons."

In any event, the threat of nuclear war must be removed before it can be reintroduced. Because physicians must constantly accommodate to "substantially new manners of thinking" in their professional work, they are highly qualified to lead the educational program about this major medical problem.

Doctors in Oklahoma and around the world have an opportunity to lend their considerable voice and particular prestige to eradicating this major hazard to life on planet Earth. As a physician, you can:

1. Support the comprehensive nuclear test ban treaty.
2. Express your views to your congressmen.
3. Educate your patients.
4. Join Physicians for Social Responsibility (PSR), the US section of IPPNW. In Oklahoma City, call Stan Shrago, MD, pathologist at Baptist Medical Center, (405) 949-3011. In Tulsa, call Joseph McDonald, MD, at (918) 742-2505. If there is no PSR chapter in your city, write to David Shorr, PSR, 1601 Connecticut Avenue, NW, Suite 800, Washington, DC 20009, or call him at (202) 939-5750. In Oklahoma City, call Robert G. Hirschi, DDS, (405) 427-1134 for information.

Robert C. Hardy, Oklahoma City, is executive of the Oklahoma Health Sciences Foundation. He has published several books, the latest of which is HERO, An Oral History of the Oklahoma Health Center, released last year.

Coming in December . . .

Papers being considered for publication in December include a manuscript on adolescent suicide and two reports from the Natalie Warren Bryant Cancer Center in Tulsa.



New Procedures for Newborn Metabolic Screening

On July 9, 1987, the State Board of Health approved new rules and procedures for newborn metabolic disorder screening. These new rules and procedures were developed after extensive consultation with private practicing physicians, the Newborn Screening Medical Advisory Committee, and the Oklahoma Hospital Association. They specifically address responsibilities of physicians, hospitals, and laboratories for newborn screening, including the requirement for screening newborns for PKU and hypothyroidism.

For physicians, the new procedures specifically address timing of specimen collection. Physicians are responsible for screening newborns within 3 to 5 days

of age prior to hospital discharge or, if discharged earlier, as close as possible to the time of discharge. Infants screened prior to 24 hours of age should be retested at 3 to 5 days of age. Additionally, physicians should selectively rescreen based on consideration of the infant's birthweight, gestational age, illness, and feeding history. Other changes address follow-up procedures for abnormal and unsatisfactory tests. Also included is a requirement for physician reporting of the results of follow-up evaluations of infants with abnormal screening tests.

Procedures for hospitals include implementing a procedure to assure that all newborns are screened prior to discharge, collection technique, documentation, parent education, follow-up and reporting, and certification standards for newborn metabolic disorder screening laboratories.

Specific details regarding these and other procedures may be found in *Oklahoma Procedures for Newborn Metabolic Disorder Screening*, which is available upon request. Additional information may be obtained by contacting the Newborn Metabolic Screening Program at the Oklahoma State Department of Health, 405/271-4471.

DISEASE	August 1987	TOTAL TO DATE		
		This Year	Last Year	5 Yr. Avg.
AMEBIASIS	1	9	6	9
CAMPYLOBACTER INFECTIONS	29	169	188	—
ENCEPHALITIS, INFECTIOUS	3	17	16	2
GIARDIA INFECTIONS	20	127	129	—
GONORRHEA (Use ODH Form 228)	849	6775	8452	9049
HAEMOPHILUS INFLUENZAE				
INVASIVE DISEASE	16	112	151	—
HEPATITIS A	21	195	237	332
HEPATITIS B	19	182	135	166
HEPATITIS, NON-A NON-B	6	37	40	—
HEPATITIS UNSPECIFIED	3	27	31	93
MEASLES (RUBEOLA)	0	3	39	14
MENINGITIS, ASEPTIC	23	119	73	112
MENINGITIS, BACTERIAL				
(non-meningococcal, non H. Influenzae)	3	32	48	44
MENINGOCOCCAL INFECTIONS	1	18	20	22
PERTUSSIS	40	111	93	129
RABIES (Animal)	3	28	48	89
ROCKY MOUNTAIN SPOTTED FEVER	17	75	75	103
RUBELLA	0	5	0	1
SALMONELLA INFECTIONS	45	258	312	273
SHIGELLA INFECTIONS	14	119	140	175
SYPHILIS (Use ODH Form 228)	7	99	107	126
TETANUS	0	1	1	1
TUBERCULOSIS	19	158	177	181
TULAREMIA	4	22	6	16
TYPHOID FEVER	0	1	1	2

Diseases of Low Frequency	Total to Date This Year
ACQUIRED IMMUNE DEFICIENCY SYNDROME	60
BRUCELLOSIS	5
LEGIONNAIRES DISEASE	20
MALARIA	3
REYE SYNDROME	0
TOXIC SHOCK SYNDROME	15

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Governor Henry Bellmon (left) discusses the final Prescription Abuse Data Synthesis (PADS) report with AMA President William S. Hotchkiss, MD, (center) and OSMA President M. Joe Crosthwait, MD. Dr Hotchkiss was in

Oklahoma in August to present the report to the governor. The nine-month, multiagency investigation of prescription drug abuse in the state was sponsored by the AMA, OSMA, and Oklahoma State Department of Health.

Despite FDA approval

Generic drug bioequivalence continues to raise questions

In 1985, generic equivalents were available for many of the 10 most prescribed prescription drugs on the market. By 1986, 1,000 such generics had received approval from the Food and Drug Administration (FDA), says a report in the *Journal of the American Medical Association*.

A 1984 federal law (the Drug Price Competition and Patent Term Restoration Act) gave the FDA a mandate to expedite approval of generic versions of brand name drugs, but prompted concerns among physicians about the thoroughness of evaluation of the generics and of their therapeutic effectiveness. Stuart L. Nightingale, MD, and James C. Morrison of the FDA respond to those issues by outlining the process and standards for approving what the FDA calls "bioequivalent" generics.

"All drug products that have the same active

ingredient(s), dosage form, strength and route of administration as the drug product originally introduced by the pioneer marketer are considered generic drug products," the authors say. But this does not always ensure that the generics are therapeutically equivalent to brand name drugs and even when they are, they may differ in other key ways: color, flavor, shape, packaging, inactive ingredients, expiration time, and even labeling, the authors note. The 1984 law permits the FDA to evaluate newly developed generics to ensure their therapeutic equivalence.

The authors present detailed information supporting the FDA stand that agency-approved generics do, in fact, "meet the same rigid FDA standards for manufacture and quality as do pioneer

(continued)

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Board of Trustees approves thirteen Life Memberships

At their September 13 meeting in Oklahoma City, the OSMA Board of Trustees approved Life Memberships for the following Oklahoma physicians:

Reece R. Boone, Jr., MD, Watonga; Francis P. Cawley, MD, Hooker; Max A. Glaze, MD, Muskogee; R. W. (Tex) Goen, Jr., MD, Tulsa; and David J. Chesler, MD, Robert B. Howard, MD, and Joseph J. Maril, MD, Oklahoma City.

To be eligible for Life Membership, a doctor must meet one or more of the following qualifications: (a) Retired from active practice of medicine due to ill health or age; (b) Engaged in the active practice of medicine for 50 years or more; (c) Attained the age of 70 years.


OSMA Life Members numbered 376 at the end of September. 

Bioequivalence (continued)

drugs." They say health professionals can prescribe such generics with the same confidence as their brand name counterparts.

However, in a related report discussing a patient who received a generic substitute for the drug primidone, Elaine Wyllie, MD, and colleagues at the Cleveland Clinic Foundation say FDA approval does not always guarantee bioequivalence. The patient, a 16-year-old girl, had multiple medical problems, including epileptic seizures. While receiving the generic medication, her seizures increased.

Without the knowledge of her attending physicians, the hospital pharmacy substituted a generic, the authors say. Even after the dosage of that generic was increased from 500 mg to 625 mg per day, the patient's condition continued to worsen. Once the physicians discovered the substitution, they immediately ordered the original medication be reinstated. The hospital pharmacy has since changed its policy to prevent substitution of that generic. A report of the incident was filed with the FDA.

"The two primidone preparations were clearly not bioequivalent in our patient, even though both were approved by the FDA. This case demonstrates that approval by the FDA does not guarantee bioequivalence," the report says. "Unfortunately, problems with generic substitution cannot be totally eliminated even with the most comprehensive in vivo and in vitro lot-to-lot bioequivalence testing," the authors conclude. 

First of its kind

Bristow High School is site of rural clinic for teenagers

What do high school students in Bristow, Okla., have in common with their peers from the inner city areas of New York City, Detroit, and Los Angeles? All of these young people have access to quality health care designed for adolescents in clinics located right in their high school.

Bristow has become the site for the United States's first school-based clinic located in a rural area and the only high school-based clinic in Oklahoma. Located on the Bristow High School campus, a complete medical clinic has been prepared that will fully serve the medical needs of adolescents. This clinic, established jointly by the University of Oklahoma Tulsa Medical College (OUTMC), Bristow Board of Education, and Bristow Memorial Hospital and its medical staff, will be state certified so it can function as a complete ambulatory medical facility. The clinic will be staffed by medical residents from OUTMC, with attending physicians from the

Bristow hospital. Comprehensive continuing medical care will be emphasized; family planning will not be provided.

"The philosophy behind setting up this clinic is that most adolescents don't seek out medical treatment since they fall in an awkward age category and don't really feel comfortable going to a pediatrician or to an adult-oriented internist," states Dr Kim Miller, faculty member at OUTMC and educational director of the rural clinic. "This clinic will provide open access for all students and will cater to the medical needs and interests of young people."

In the other school-based clinics across the country, a survey showed that over 90% of the students used the clinic an average of three times a year. Miller hopes that Bristow students will use the clinic often since it was established to provide increased medical care just for adolescents.

(continued)



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Bristow clinic (continued)

Since Bristow is the first school-based medical clinic to be placed in a rural area, many researchers are looking forward to studying the lives and health of rural students compared to inner-city students. The research base that the Bristow clinic will provide could eventually give physicians useful information about adolescent health care and social development.

Miller states that OUTMC also will benefit from the school clinic. OUTMC residents will gain valuable experience in adolescent medicine as well as see first-hand what it is like to practice medicine in a small community. Private physicians from Bristow Memorial Hospital will work closely with the medical residents daily and will provide insight into rural medical needs.

Clinic services will be available to students during regular school hours as well as after school until 3:30 PM. The clinic will be staffed daily by a medical resident and medical aide. 



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Proponents don't understand

Mandatory premarital HIV test considered inefficient, costly

Mandatory premarital screening for human immunodeficiency virus (HIV) would be a "relatively ineffective and inefficient use of resources" because of the low overall prevalence of infection in the population that would be tested, a study in the *Journal of the American Medical Association* concludes.

One year of mandatory premarital screening in the US would cost more than \$100 million but detect fewer than 0.1% of HIV-infected individuals, Paul D. Cleary, PhD, of the Harvard School of Public Health, Boston, and colleagues say. "More than 100 infected individuals would be told that they were probably not infected, and there would be more than 350 false-positive results," they add.

"Public education, counseling of individuals, and discretionary testing can be important tools in reducing the spread of HIV infection," the authors conclude, "but mandatory premarital screening in a

population with a low prevalence of infection is a relatively ineffective and inefficient use of resources."

The authors note there are no broad-based studies on HIV prevalence in people planning marriage. Therefore, they base their estimates on other available data, including government figures on numbers of marriages and known prevalence data for low-risk populations, such as blood donors.

In a given year, they estimate, 3.8 million people planning marriage would be screened. Some 9,000 would test positive on the screening enzyme immunoassay but, based on low-risk prevalence data, only about 1,300 would be expected actually to be infected. As a result, confirmatory Western blot analysis would be needed, they note, with about 1,200 infected persons showing up positive on both tests. The study estimates total costs for screening, confirmatory testing and counseling at more than \$100 million.

(continued)



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Premarital HIV test (continued)

Detecting 1,200 cases in this way presumably could prompt the behavior changes needed to stem HIV spread, but this benefit would be reduced by the fact that the virus already would have been transmitted in some couples during premarital sex, the report says. Another potential benefit would be reducing the number of HIV-infected infants born to such couples, but the authors estimate screening would prevent only about 250 such births — about half the number of potential births.

Since key assumptions used in the analysis could change, the authors refigured their estimates assuming higher infection prevalence and improved test accuracy. These calculations yielded “substantially better” results, but “in our opinion, it is arguable whether they represent the type of results that would be sufficient to justify such an expensive program with a small yield to the relative size of the problem, when more effective uses of resources are available.”

The report says premarital syphilis screening,

cited as precedent for HIV testing, in fact is an example of a universal screening policy “abandoned primarily because (it has) not effectively served the public good.” Premarital syphilis tests have “seldom identified previously undetected cases,” accounting for only about 1% of all positive syphilis tests in 1978 but costing an estimated \$80 million, the authors say. “Thus, the program that is often cited as a precedent for HIV screening has itself been judged to be ineffective and unnecessary.”

“Many people believe that compulsory screening is a way to stop the spread of HIV, but such attitudes reflect a misunderstanding of the epidemiology of HIV infection and the performance of diagnostic tests,” the report says. “The more resources we devote to such marginally effective ventures, the fewer resources we will have to develop truly effective public health programs.”

A comprehensive public health education effort, including premarital counseling and voluntary testing, has the greatest potential for reducing HIV spread, the authors conclude.



AIM HIGH

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He was my friend

Someone conceives of the idea, but others oftentimes capitalize on the idea and expand it to their benefit. Rex Kenyon, MD, was at the cutting edge of many fruitful ventures which paved the way for others.

In the early 1960s he and others started the AMA's present fruitful PAC movement.

He was my classmate — oftentimes my mentor — but most of all, my friend. To enumerate his multitude of accomplishments is not now

necessary. Suffice it to say he monumentally enhanced the way I, who chose rural practice, could serve my patients and hospital. He pioneered medical lab pickup systems.

I shall remember Rex as an innovative and intelligent physician. He was well thought of on the national level at the AMA. Medicine has lost a valuable friend.

*Ed Calhoon, MD
Beaver*

New test coming to Oklahoma

Blood supply to become safer with test to find AIDS virus

The Oklahoma Blood Institute is slated to be among the first blood banks in the nation to screen its blood supply for the AIDS or human immunodeficiency virus (HIV). Older screening methods detect only the HIV antibody, not the virus itself.

Ronald O. Gilcher, MD, institute director, says research on the new procedure is in progress, and the new test should be available within the next six months.

"The new test," says Gilcher, "will close the window on the possibility that tainted blood could go undiscovered."

That window is the ten-day to three-month period between exposure to the HIV virus and development of the HIV antibody. Blood donated during that period would test negative by current procedures, positive with the new test. □

For both parties

Shame and humiliation impair doctor-patient relationship

Patients are at high risk for experiencing shame or humiliation in any medical encounter, yet this important aspect of interaction between patient and health professional is often neglected, suggests a report in September's *Archives of Internal Medicine*.

Shame and humiliation enter as factors since patients often perceive diseases as defects, inadequacies, or shortcomings, writes Aaron Lazare, MD, of the University of Massachusetts Medical Center, Worcester, while at the same time, a visit to the hospital or doctor's office requires physical and psychological exposure.

"Patients respond to the suffering of shame and humiliation by avoiding the physician, withholding information, complaining, and suing," Lazare says. "Physicians may also experience shame and humiliation in medical encounters resulting in their counterhumiliation of patients and dissatisfaction with medical practice."

A heightened awareness of these issues can help physicians lessen the severity of the problem in both patients and themselves, says Lazare, who offers a dozen clinical strategies for managing the problem. The significance of the issue probably has been ignored for a number of reasons, he notes, including the fact that "neither patients nor physicians like to acknowledge or discuss their own shame and humiliation." □

OSMA
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BOOK SHOP

Pathophysiology: The Biologic Principles of Disease. By Lloyd H. Smith, Jr., and Samuel O. Thier (*International Textbook of Medicine*, Vol. 1, A. H. Samiy, L. H. Smith, Jr., and J. E. Wyngaarden, editors). Philadelphia: W.B. Saunders Co., 1981, pp 1,918, illus, \$65.00.

This book was prepared as part of the three-volume *International Textbook of Medicine*. It is to be accompanied by two companion works, *Medical Microbiology and Infectious Diseases* (edited by Brands, Davis, and Fierer) and the 1982 edition of the *Cecil Textbook of Medicine* (edited by Wyngaarden and Smith).

In this textbook the editors and authors provide a thorough and contemporary analysis of the scientific foundation of current medical practice. It provides an interesting and usable approach to the presentation of pathophysiology and is made up of 16 chapters. In addition to chapters on the major body systems, there are sections devoted to important biomedical concepts such as cell biology, genetics, and immunology. There is also a chapter on the fundamentals of neoplasia and one on clinical pharmacology.

The remaining text is organized chiefly in the context of systems pathophysiology. Each of the chapters is prepared by individuals important in that particular field. Generally speaking, the writing is clear and the structure of individual chapters is quite reasonable. The text is complimented by figures and tables of good quality. The references are thoughtfully chosen (although at least one section contains no references) and the index is well done.

(continued)

IN MEMORIAM

1986

Marcella Steel, MD	October 1
Terry Dwight Leming, MD	October 13
William Pat Fite, Jr., MD	October 30
Samuel Jackson McDaniel, MD	November 2
Iron Hawthorne Nelson, MD	November 12
John Robert Walter Spencer, MD	December 4

1987

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Lawrence Edward Silvey, MD	April 9
Victor Gary Anderson, MD	April 10
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John Wesley Williams, MD	May 16
John Jerome Coyle, MD	May 21
Scott Allen Morris, MD	May 24
Gladys Christine Smith, MD	May 27
John Ronald Watson, MD	June 14
Thomas Arthur Hosty, MD	June 17
Dan Cross Galloway, MD	July 12
Alwin Marshal Clarkson, MD	September 1
Rex Elmer Kenyon, MD	September 16

DEATHS

Alwin Marshal Clarkson, MD 1903 - 1987

OSMA Life Member Alwin M. Clarkson, MD, died September 1, 1987, at his home in Idabel. Dr Clarkson, a general practitioner in Idabel since the early 1940s, was born in Manchester, Texas, and was graduated from the University of Oklahoma School of Medicine in 1926. He retired in 1969.

Rex Elmer Kenyon, MD 1924 - 1987

Rex E. Kenyon, MD, OSMA president in 1965-66, died September 16, 1987, in Oklahoma City. A pathologist, Dr Kenyon was graduated from the University of Oklahoma School of Medicine in 1951. In 1964 he was elected president of the Oklahoma County Medical Society. The same year he was named to the AMA's National Speakers Bureau. He was also chairman of the Oklahoma Medical Political Action Committee and national chairman of the American Political Action Committee. Beginning in 1979, he served as a state delegate to the American Medical Association.

H.M.S.

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MISCELLANEOUS ADVERTISEMENTS

Book Shop (continued)

It is hoped that subsequent editions might include a section dealing with the pathophysiology of abnormal processes that are not organ specific, such as fever.

This new textbook of pathophysiology should attract wide appeal among medical students and physicians at all levels of training and in practice.

Harris D. Riley, Jr., MD
Oklahoma City

Pediatric Urology. Edited by D. Innes Williams and J.H. Johnson. London: Butterworth Scientific, 1982, pp 581, illus, \$115.00

Pediatric Urology first appeared in 1968 and rapidly became a standard reference in the field. In view of the advances in this specialty in the subsequent 15 years, a new edition is certainly welcomed.

The two editors, who are among the foremost authorities in pediatric urology, are joined by 17 other contributors in this edition. The volume comprises 48 chapters, which cover thoroughly the urologic problems of infancy and childhood. The other contributors include pediatricians, pediatric nephrologists, pediatric endocrinologists, pediatric radiologists, and other child health specialists. The diversity of the contributors reflects the growing collaboration of pediatric urology with other disciplines such as pediatric nephrology, radiology, and pathology.

For the most part the chapters cover the topics concisely. The references at the end of each chapter are carefully chosen. The themes of most chapters are broad so that they appeal not only to pediatric urologists but also to physicians in other disciplines.

The technical characteristics of the book deserve comment. The paper is high grade, the reproduction of roentgenograms and other photographs is excellent, and the style is very readable.

This book is highly recommended to all who treat children with problems of the genitourinary tract.

Harris D. Riley, Jr., MD
Oklahoma City

**The January OSMa JOURNAL
closes December 1**

Miscellaneous advertising is available at the rate of \$11 per month per vertical inch or any portion thereof (ie, 1-7 lines is \$11, 8-14 lines is \$22, etc). Rates are not prorated for fractions of an inch. One inch of space contains 7 lines of copy averaging 55 characters each. The first line of the ad will automatically be set in all capital letters and averages only 38 characters. Count every letter, space, and punctuation mark as a character.

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BRIEF SUMMARY

CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate.

PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that the simultaneous administration of CARAFATE with tetracycline, phenytoin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. The clinical significance of these animal studies is yet to be defined.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No evidence of drug-related tumorigenicity was found in chronic oral toxicity studies of 24 months' duration conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies have not been conducted.

Pregnancy: Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED

CARAFATE (sucralfate) 1-gm pink tablets are supplied in bottles of 100 and in Unit Dose Identification Paks of 100. The tablets are embossed with MARION/1712. Issued 3/84

References:

1. Grossman MI: *Scand J Gastroenterol* 58 (suppl 15): 7-16, 1980.
2. Marks IN, in Hellemans J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly*. Edinburgh, Churchill Livingstone, 70-81, 1984.
3. Krentz K, Jablonowski H, in Hellemans J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly*. Edinburgh, Churchill Livingstone, 62-69, 1984.



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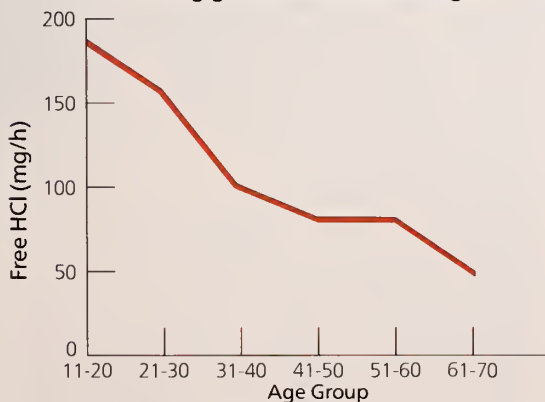
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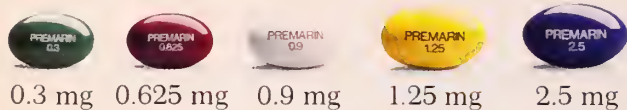
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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION SEE PACKAGE CIRCULARS)

PREMARIN® Brand of conjugated estrogens tablets, USP

PREMARIN® Brand of conjugated estrogens Vaginal Cream, in a nonliquefying base

1 ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA. Three independent case-controlled studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case-controlled studies reported that the risk of endometrial cancer in estrogen users was about 4 to 5 to 13 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semi-annual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration. It therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equi-estrogenic doses.

2 ESTROGENS SHOULD NOT BE USED DURING PREGNANCY. The use of female sex hormones, both estrogens and progestins, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing, in later life, a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case-controlled study estimated a 4- to 7-fold increased risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestins are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17 α -dihydroequilin, together with smaller amounts of 17 α -estradiol, equilin, and 17 α -dihydroequilin and salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe vasomotor symptoms associated with the menopause (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) Osteoporosis (abnormally low bone mass). Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae.

PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens (See PRECAUTIONS). The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (see Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Estrogens have been reported to increase the risk of endometrial carcinoma (see Boxed Warning). However, a recent large case-controlled study indicated no increase in risk of breast cancer in postmenopausal women. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

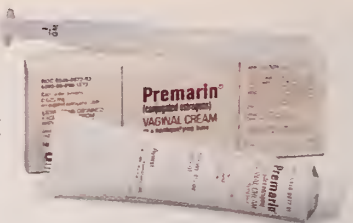
Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement, it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism, and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

For atrophic vaginitis

PREMARIN® (conjugated estrogens)

Vaginal Cream

0.625 mg/g



Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention, such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Pre-existing uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not yet complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

- Increased sulfobromophthalen retention
- Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability
- Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T_4 by column, or T_4 by radioimmunoassay. Free T_3 resin uptake is decreased, reflecting the elevated TBG. Free T_4 concentration is unaltered
- Impaired glucose tolerance
- Decreased pregnandiol excretion
- Reduced response to methylprednisolone
- Reduced serum folate concentration
- Increased serum triglyceride and phospholipid concentration

As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

Long-term, continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. However, in a recent, large case-controlled study of postmenopausal women there was no increase in risk of breast cancer with use of conjugated estrogens.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow, dysmenorrhea, premenstrual-like syndrome, amenorrhea during and after treatment, increase in size of uterine fibromyoma, vaginal candidiasis, change in cervical erosion and in degree of cervical secretion, cystitis-like syndrome, tenderness, enlargement, secretion (of breasts), nausea, vomiting, abdominal cramps, bloating, cholestatic jaundice, chloasma or melasma which may persist when drug is discontinued, erythema multiforme, erythema nodosum, hemorrhagic eruption, loss of scalp hair, hirsutism, steepening of corneal curvature, intolerance to contact lenses, headache, migraine, dizziness, mental depression, chorea, increase or decrease in weight, reduced carbohydrate tolerance, aggravation of porphyria, edema, changes in libido.

ACUTE OVERDOSSAGE: May cause nausea and withdrawal bleeding may occur in females.

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1. Given cyclically for short-term use only. For treatment of moderate-to-severe vasomotor symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 mg to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. Given cyclically. Osteoporosis. Female castration. Osteoporosis—0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off). Female castration—1.25 mg daily cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

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Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals. Usual dosage range, 2 g to 4 g daily intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References

1. Lindsay R, Hart DM, Clark DM. The minimum effective dose of estrogen for prevention of postmenopausal bone loss. *Obstet Gynecol* 1984;63:759-763. 2. Studd JWW, Thom MH, Paterson MEL, et al. The prevention and management of endometrial pathology in postmenopausal women receiving exogenous estrogens, in Pasetto N, Paoletti R, Ambrosi JL (eds) *The Menopause and Postmenopause*. Lancaster, England, MTP Press Ltd, 1980, chap 13.

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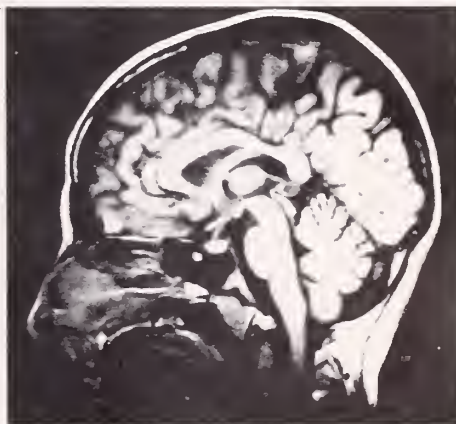
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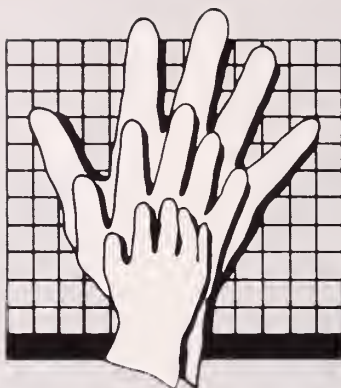
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Illustrations other than the author's will not be accepted for publication unless accompanied by written permission from the original source. Illustrations should be labeled with the author's name and must be numbered in the order in which they are referred to in the article. The quality of all illustrations must be in keeping with the quality of the magazine.

News

Readers are encouraged to submit news items of interest to Oklahoma physicians. Where dates of meetings, etc, are important, please remember that each issue closes on the first day of the *preceding* month and reaches subscribers in the latter half of the month of publication.

Reprints

Authors will receive reprint order forms from the Transcript Press, 222 East Eufaula, Norman, Oklahoma 73069, prior to publication of their articles. Other requests for reprints must be made to the Transcript Press within 30 days after publication.

Back Issues

Microfilm copies of back issues of the JOURNAL can be purchased from University Microfilms International, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

AMA-ERF

In the 35 years since its inception, the American Medical Association Education and Research Foundation (AMA-ERF) has consistently supported quality medical education in the United States. This is currently made possible through several funds. The Medical School Excellence Fund provides grants to medical schools throughout the nation to use as they see fit. This is the oldest and largest of the funds. At Oklahoma's three medical schools, funds are used in various ways: books for their medical libraries, computers, speakers for student programs, and equipment for teaching and for student research. The newest fund (1983), the Medical Student Assistance Fund, provides funds for medical schools to use in direct financial assistance to students. Medical school deans make these gifts available to students as long-term loans at very low interest rates and with longer payback time.

The Development Fund is used at the discretion of the AMA-ERF Board of Directors to support pilot and experimental health and medical programs. Categorical Funds for specific research areas are also available. Our endeavors help complete the never-ending cycle of education: giving, receiving, and giving back.

Contributions to AMA-ERF in 1986-87 now equal over \$2,000,000. These gifts resulted from efforts of both AMA Auxiliary and the Foundation. The funds provided to each school are determined by the donors, including 50,000 physicians who designate beneficiary schools.

Raising funds for AMA-ERF has been the AMA Auxiliary's sole, national philanthropic endeavor for more than 30 years. The holiday sharing card project

is the easiest and most successful fund-raiser that auxiliaries can implement. Some counties have expanded the theme and are having Thanksgiving, Valentine, and Doctor's Day sharing cards. Also, some counties and states send sharing cards to legislators, medical school deans, and hospital administrators. Other fund-raising projects include tennis parties, garage sales, costume parties, football parties, cooking classes, art sales, an International dinner/dance, and a country hoedown. AMA-ERF receives 40% to 50% sales commission on all Christmas card sales.

Donations given in the form of memorials, thank-you's, and physician courtesy cards are unique ways for medical society members to remember family, friends, or colleagues or to honor someone for a task well done.

We want to enhance the AMA's goal this year to improve the image of the medical family, by demonstrating how contributing to AMA-ERF places physicians and their families in a positive light within the community. To attain these goals, we need to start now! Be generous in your donations to this charitable cause. Your entire donation is tax deductible, and you may designate the particular school you wish to receive your donation. The extraordinary fund-raising efforts of the AMA Auxiliary and the generosity of contributing medical families have secured AMA-ERF's past effectiveness and assure its future success.

*Dawn Wood
Oklahoma State Auxiliary
AMA-ERF Chairman*

THE LAST WORD

■ **James W. Hampton, MD, Oklahoma City** oncologist-hematologist, has been named 1987 Physician of the Year by the Association of American Indian Physicians (AAIP). The award, a surprise to Dr Hampton, was presented early this fall at the AAIP annual meeting in Spokane, Wash. Before coming home, Dr Hampton was also named AAIP president-elect for the second time. His term will begin in 1988.

■ **The musical talents of Tulsa allergist David S. Hurewitz, MD,** are the focus of an article in September's *Tulsa Medicine*. Dr Hurewitz, who has played the clarinet and saxophone for many years, started playing the clarinet when he was 13 years old. He still plays the instrument he was given then.

■ **Philip Mosca, MD, Oklahoma City,** has been appointed to a three-year post as Cancer (Field) Liaison Physician to the American College of Surgeon's Commission on Cancer. The commission is composed of college fellows and liaison members representing 24 cancer-related organizations. It reviews cancer programs for conformity to commission standards and has approved more than 1,100 hospital cancer programs. The Cancer (Field) Liaison Program is a nationwide network of 2,400 volunteer physicians.

■ **Dan M. Lane, MD, Oklahoma City,** devoted several days this summer to developing his political skills. He was one of ten physicians to attend the fourth Campaign Management School conducted by the American Political Action Committee (AMPAC) of the AMA. The school graduates active election campaign volunteers, and this year's class was notable for its high percentage of physician participants (10 of 23).

■ **Declining autopsy rates are an international** problem, says a report in September's *Archives of Pathology and Laboratory Medicine*. The report, by Einar Svendsen, MD, PhD, of the University of Bergen, Norway, and Rolla B. Hill, MD, a private practitioner in Philo, Calif, reviews information on autopsy laws, regulations, rates, and practice in 29 industrialized nations. Laws in many countries have been revised in recent years, introducing more restrictive rules, with consent required from

next-of-kin, the study finds. With one exception — Finland — introduction of a requirement for consent was followed by a decline in the autopsy rate, the authors report. "In view of the importance of autopsy to society, an international effort to educate the public and increase autopsy utilization is imperative," the report concludes.

■ **Advocating an electroencephalogram (EEG)** as a confirmatory test of brain death may be of little value, since EEG activity can still be recorded even after clinically determined brain death occurs, says a report in September's *Archives of Neurology*. Over a 29-month period, Madeleine M. Grigg, MD, of the Stritch School of Medicine, Loyola University of Chicago, Maywood, Ill, and colleagues studied 56 patients clinically diagnosed as brain dead. Eleven of these had EEG activity following diagnosis of brain death, says the report. The activity, of varying patterns, was an average of nearly 37 hours in duration but lasted as long as 168 hours, the authors say. Regardless of EEG activity, the report notes, none of the 11 patients recovered; all fulfilled stringent clinical brain death criteria. "The relatively frequent occurrence of EEG activity after brain death would suggest reliance on the EEG to confirm brain death may be unwarranted," the report concludes.

■ **A report in September's *Archives of Internal Medicine*** examines why many doctors still recommend aggressive surgery for localized breast cancer, even though recent studies suggest conservative surgery can yield similar survival rates. Raisa B. Deber, PhD, and Gail G. Thompson, of the University of Toronto, asked 228 Canadian oncologists and surgeons to recommend treatment for a hypothetical breast cancer patient; 30% favored modified radical mastectomy, 69% less aggressive surgery. The mastectomy group, although equally aware of the value of clinical trials, was more skeptical than the other about the ability of trial results to transfer to clinical practice and to take account of the uniqueness of individual patients. The authors say study results might be more readily adopted if they were also reported in accessible databases, giving doctors enough information about various patient subsets to allow them to individualize treatment decisions. □

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Prevention of hypokalemia requires particular attention in patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis and ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, certain diarrheal states, or other states where hypokalemia is thought to represent particular added risk to the patients.

In patients with hepatic cirrhosis and ascites, sudden alterations of electrolyte balance may precipitate hepatic encephalopathy and coma. Treatment in such patients is best initiated in the hospital with small doses and careful monitoring of the patient's clinical status and electrolyte balance. Supplemental potassium and/or spironolactone may prevent hypokalemia and metabolic alkalosis in these patients. In cats, dogs and guinea pigs, Bumex has been shown to produce ototoxicity. Since Bumex is about 40 to 60 times as potent as furosemide, it is anticipated that blood levels necessary to produce ototoxicity will rarely be achieved. The potential for ototoxicity increases with intravenous therapy, especially at high doses.

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OKLAHOMA STATE MEDICAL ASSOCIATION

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Most of us are aware of our great good fortune and are thankful, in varying degrees, for our endowments. In our hearts we sense the favors of a divinity and privately confess our gratitude; sometimes even our subserviency.

Too often, however, we avoid the behavior that publicly reveals an awareness of the source of our blessings. We speak of our skills and our knowledge and our talents as though they were our personal creations. We boast of our accomplishments as though they were triumphs of solitary effort. When we achieve our goals, earn prestige, enjoy success, and win the respect of our patients and our colleagues, we yield quickly to the temptations of vanity. We become important. We become omnipotent.

We heal the sick. We stop the pain. We repair the torn and broken bodies. We discover the cures. We tell patients how to live their lives. We diagnose their illnesses. We forecast their fates. We save their lives.

Rarely do we assume the slightest culpability for failing to do those things we eagerly accept credit for accomplishing. We assign such misfortunes to divine judgment, an influence we almost never acknowledge in our successes.

Particularly at this time of year, it seems appropriate that we pray for one more gift. A gift that would have us admit that we are instruments of a divinity; that we are true servants, subservient in our successes as well as in our failures; that we are indebted and vulnerable and even fallible.

Let us pray for the gift that can turn us away from vanity and lead many of us to greatness. The gift that will enrich every day of our lives, and glorify every memory of us after the days of our lives have ended.

Let us pray for the most precious gift of all.

Let us pray for humility.

—MRJ

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Intrathecal Morphine for Cancer Pain Control

GREGORY A. PARKER, MD; DAVID A. FELL, MD; JAMES A. YOUNG, MD

The use of intermittent intrathecal bolus injections of morphine via an implanted reservoir can be a safe and effective adjunct to the management of severe pain in selected cancer patients.

Injection of narcotic analgesics into the subarachnoid space has been shown to elevate the pain threshold in laboratory animals,¹ and there has been great interest in the clinical application of this technique for the control of pain refractory to conventional therapy. Intraspinal opiates exert their analgesic effects by interacting with opiate receptors in the dorsal horn substantia gelatinosa,² and morphine sulfate, with its poor lipid solubility and relatively long duration of analgesia, is well suited for such use.²

Several studies have demonstrated that the intrathecal administration of narcotics is effective in controlling severe chronic pain of malignant origin, and that the duration of analgesia is prolonged when compared to other routes of administration.³⁻⁷ Few undesirable side effects have been reported in this patient population.⁶ In contrast, intrathecal narcotic injection for acute postoperative pain may be associated with a significant risk of central nervous

system and cardiorespiratory depression.⁸⁻¹¹ This report reviews our clinical experience with intrathecal morphine sulfate in patients with intractable pain due to cancer.

Materials and Methods

Between February 1981 and May 1985, we evaluated fourteen patients with refractory cancer-related pain for intrathecal injection of morphine sulfate. All had intolerable side effects or inadequate control of pain by conventional oral or parenteral narcotics. Two patients with paraparesis secondary to metastatic disease were evaluated for control of pain above the level of spinal cord compression. Twelve patients received trial bolus injections of sterile, preservative-free morphine sulfate by lumbar puncture. An initial dose of 1 mg was infused, and the duration and effectiveness of analgesia noted. Subsequent dose and dosing interval were adjusted on an individual basis. If the patient experienced satisfactory pain relief without clinically significant side effects, this was considered a positive response. Ten of the twelve patients given trial injections had an adequate analgesic response and underwent surgical placement of an Ommaya reservoir. Two of the twelve patients failed to respond to their trial intrathecal morphine injections, and were excluded from this

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Table 1. Patients Selected to Receive Intrathecal Morphine

Patient	Diagnosis	Age	Sex	Site(s) of Pain	Site of Implantation
1	Carcinoma of cervix	57	F	Low back, pelvis	L ₅ - S ₁ interspace
2	Carcinoma of lung	57	M	Low back	L ₃ - L ₄ interspace
3	Carcinoma of colon	60	M	Low back, pelvis	L ₄ - L ₅ interspace
4	Carcinoma of colon	38	F	Low back, pelvis	L ₃ - L ₄ interspace
5	Carcinoma of lung	75	M	Thoracic spine	L ₅ - S ₁ interspace
6	Multiple myeloma	61	M	Thoracic and lumbar spine, legs, right arm	L ₅ - S ₁ interspace
7	Carcinoma of lung	66	F	Right shoulder, thoracic spine	L ₅ - S ₁ interspace
8	Carcinoma of lung	69	M	Thoracic spine	L ₅ - S ₁ interspace
9	Carcinoma of lung	63	M	Left shoulder, and arm	T ₁ - T ₂ interspace
10	Renal cell carcinoma	60	M	Pelvis	T ₁₁ - T ₁₂ interspace
11	Carcinoma of lung	58	F	Right arm, shoulder and neck	Rt. frontoparietal skull
12	Carcinoma of colon	72	M	Low back, pelvis, legs	Rt. frontoparietal skull

analysis. Two additional patients had reservoirs placed without trial injections.

An Ommaya reservoir catheter was placed in the subarachnoid space via hemilaminectomy in ten patients, and by craniotomy in two patients. The initial dose and interval of intrathecal morphine sulfate were determined by the response to test doses, and the subsequent doses and intervals of the injections were adjusted on an individual basis. In selected cases, patients' families were instructed in injection technique so that outpatient management was possible.

The analgesic efficacy of this technique was estimated retrospectively, using data obtained from the patients' hospital records and interviews with family members. Preimplant and postimplant performance status (Eastern Cooperative Oncology Group)¹² was estimated retrospectively. The total 24-hour narcotic consumption before and after implantation of the reservoir was estimated for each patient in an equivalent dose of parenteral morphine sulfate using conversion methods described elsewhere.¹³ Statistical analysis of the difference in preimplant and postimplant narcotic consumption was performed utilizing a t-test for paired data.

Results

Of the twelve patients selected to receive intrathecal morphine via Ommaya reservoir, eight were male and four were female. The median age was 61 years (range 38 to 75 years). Six patients had carcinoma of the lung, three patients had carcinoma of the colon, and one patient each had multiple myeloma, renal cell carcinoma, and carcinoma of the cervix. Seven patients had pain largely localized to the low back and pelvis, whereas the remaining five patients

had pain in the thoracic spine and upper extremities (Table 1). Eleven patients were totally bedfast (ECOG performance status 4), and one was confined to bed greater than 50% of the time (ECOG performance status 3). Of the ten patients available for follow-up, only patient number 1 is still living at the time of this writing.

Two patients failed to achieve pain relief from test doses of intrathecal morphine. Patient 13 had squamous carcinoma of the lung metastatic to the spine, and patient 14 had adenocarcinoma of unknown primary, widely metastatic to liver, brain, ribs, spine, and sacrum. Both required continuous intravenous morphine for control of back pain.

Table 2 details the results of this treatment. The mean preimplant consumption of narcotic analgesic (expressed in equivalent doses of parenteral morphine sulfate) was 104.55 (\pm 54.35) mg/24 hr, and the mean postimplant supplement consumption was 16.62 (\pm 20.27) mg/24 hr ($p < 0.001$). The mean intrathecal morphine dose was 14.2 (\pm 18.03) mg/24 hr. The mean dose frequency was 1.4 (\pm 0.7) per 24 hr. Of ten patients evaluable for performance status at the time of discharge, five improved by one grade, and two improved by two grades or more. Two patients could not be evaluated in this manner because of paraparesis due to metastatic disease, but each reported excellent subjective pain control.

Two patients were lost to follow-up after hospital discharge (patients 2 and 6). The median duration of therapy in the other ten patients was four months (range 0.5-28 mos). Patients 7, 10, and 12 developed complications from their underlying malignancies and died during the hospital stay. The other nine patients were managed at home, receiving their injections from trained family members. Anti-depressant adjuvant therapy was used in one patient

who had been on this medication prior to intervention. Drug tolerance, mandating an increase in the dose or frequency of intrathecal morphine, occurred in five of ten evaluable patients.

Complications from the Ommaya reservoir were observed in four patients. Patient 1 developed a staphylococcal paraspinal abscess, osteomyelitis, and meningitis after 22 months of use. The reservoir and catheter were removed, and the patient recovered completely. Patient 2 reported a single episode of aspirating blood from the reservoir. Patient 5 developed a pseudomeningocele, without functional impairment of the reservoir. Patient 10 developed a subcutaneous cerebrospinal fluid leak around the reservoir, requiring surgical repair. Minor side effects from intrathecal morphine were observed in two patients. Patient 2 had a self-limited episode of apnea after injection of the test dose. Patient 9 reported a single brief episode of urinary retention.

Discussion

Yaksh and associates first reported pain blockade by subarachnoid administration of opiates in laboratory animals.¹ Soon thereafter, Wang reported successful pain control in eight patients with intractable pain due to cancer via intrathecal injection of morphine.³ Subsequent reports have examined the effectiveness of this technique in controlling severe pain of

malignant origin. Coombs recently reported successful use of the Infusaid pump for continuous intraspinal narcotic therapy for patients with refractory cancer-related pain.¹⁴ Our series began before widespread availability of implantable infusion pumps and employs the less costly Ommaya reservoir for bolus intrathecal morphine injection.

We conclude that the use of intermittent bolus injections of intrathecal morphine via an implanted reservoir is a safe, effective, and valuable adjunct to chronic pain management in carefully selected patients with intractable pain due to cancer. While the large majority of patients with cancer-related pain may be successfully managed with conventional oral or parenteral administration of narcotic analgesics, some patients have poor pain control and/or unacceptable side effects with standard therapy. It is in this patient population that the intrathecal administration of narcotics may be useful.

Based on our experience with this technique, we offer the following criteria for the selection of patients for placement of an Ommaya reservoir for intrathecal morphine sulfate therapy:

- 1. The pain should be determined to be of malignant origin.
- 2. The patient has inadequate relief of pain and/or intolerable side effects with conventional pain control measures.

Table 2. Results of Treatment with Intrathecal Morphine

Patient	Preimplant		Postimplant				
	Performance Status (ECOG)	Opiate Intake/24h (MSEq)*	Intrathecal Morphine/24h	Supplemental Opiates (MSEq)*	Performance Status	Duration of Therapy (mos)	Tolerance Reported
1	4	128.0	1.0	3.2	2	22	No
2***	4	42.6	5.0	3.2	3	—	—
3	4	52.4	4.0	0.0	4**	5	Yes
4	4	213.0	40.0	33.0	3	4	No
5	4	32.0	4.5	1.6	3	4	No
6***	4	80.0	3.0	12.0	4**	—	—
7	4	227.0	45.0	65.0	4	1	Yes
8	4	80.0	12.0	25.0	1	28	Yes
9	4	120.0	4.0	40.0	3	1	No
10	4	160.0	46.0	5.4	4	2.5	Yes
11	3	80.0	5.0	10.0	2	4	Yes
12	4	42.6	1.0	1.0	4	0.5	No

* MSEq = Equivalent doses of parenteral morphine sulfate
** Patients 3 and 6 were paraplegic, preventing evaluation by performance status
*** Patients 2 and 6 were lost to follow-up

3. There is no known allergy to morphine sulfate.
4. Trial injections of intrathecal morphine sulfate result in acceptable relief of pain.

Conclusion

The data presented in this report demonstrate a significant reduction in the total narcotic requirement following Ommaya reservoir placement and intrathecal injection of morphine. Intrathecal opiate adjuvant therapy allowed adequate control of pain in this patient population with lower doses of oral and parenteral narcotic analgesics and fewer associated side effects. Family members were able to master the injection technique for pain control at home. Significant side effects from the Ommaya reservoir or drug were rarely observed, and most patients had an improved level of activity and function after this intervention.

There are several limitations in this retrospective study that should be addressed. Quantitative assessment of the degree of pain reduction (eg, pain scales) was not performed. Likewise, prospective assessment of drug tolerance was not documented. In retrospect, we can state only that drug tolerance sufficient to result in dosage escalation occurred in 50% of our patients, but the rate of development could not be assessed. The influence of depression on pain management was not assessed in our patients, although only one patient in our series was treated with antidepressant medication. These issues could be addressed more effectively in a prospective study. J

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A timely note

Our mission is of the highest and of the noblest kind, not alone in curing disease but in educating the people in the laws of health, and in preventing the spread of plagues and pestilences.

— Sir William Osler

Concurrent Combined Chemotherapy and Radiation Therapy in Gastrointestinal Cancers

THEODORE J. BRICKNER, JR., MD; GARY F. GILBERTSON, MD; WILLIAM C. STONE, MD

The use of combined 5-FU infusion chemotherapy and external beam radiation therapy has proven remarkably effective in treating epidermoid carcinomas of the gastrointestinal tract.

Squamous cell cancer of the anal region frequently requires the use of wide surgical excision for management. This often results in an abdominal perineal resection with a permanent colostomy to control a rather small volume of tumor. Local excision is applicable only in the early stages of disease for small tumors outside of the anal canal and is usually limited to well differentiated lesions. Radiation therapy, including interstitial radioactive materials implantation, has been used with variable results. The complications of high-dose local radiation have frequently led to surgery, resulting in permanent colostomies, permanent loss of sphincter function, or significant stenosis.

Methods

Nigro, Sischy, and others have reported on the use of concurrent combined therapy.¹⁻⁶ This consists of external beam radiation to doses of 3,000 to 5,000

rad to the area, with an infusion of 5-fluorouracil (5-FU) chemotherapy for several days during the first week of treatment.

The infusion begins on Day 1 or Day 2 and consists of 1,000 mg/M² of body surface per 24 hours. This usually lasts for 96 hours. Normally on the first day of chemotherapy, a single bolus of mitomycin-C is administered at 10 mg/M². During the fifth week, Day 28 through 31, a second identical infusion of 5-FU is given without mitomycin-C bolus. From this work, we have settled on a treatment for the disease at our institution as follows:

Day 1 through Day 35, treatment is given to the whole pelvis, perineum, and inguinal nodes through anterior and posterior opposed supervoltage fields. A midplane dose of 160 rad per day is given with supervoltage radiation for a total dose of 4,000 rad in 25 fractions over 5 weeks. A 5-FU infusion of 1,000 mg/M² per day is begun on Days 1 through 4 and Days 28 through 31. In most cases, a single IV bolus of mitomycin-C is administered on the first day of chemotherapy at 10 mg/M².

On completion of the above regime, a rest break is usually given because of perineal skin reaction. This break is usually two weeks in length. It is followed by completion of the treatment with a direct perineal supervoltage field, delivering eight treatments of 200 rad per day. In this manner, the

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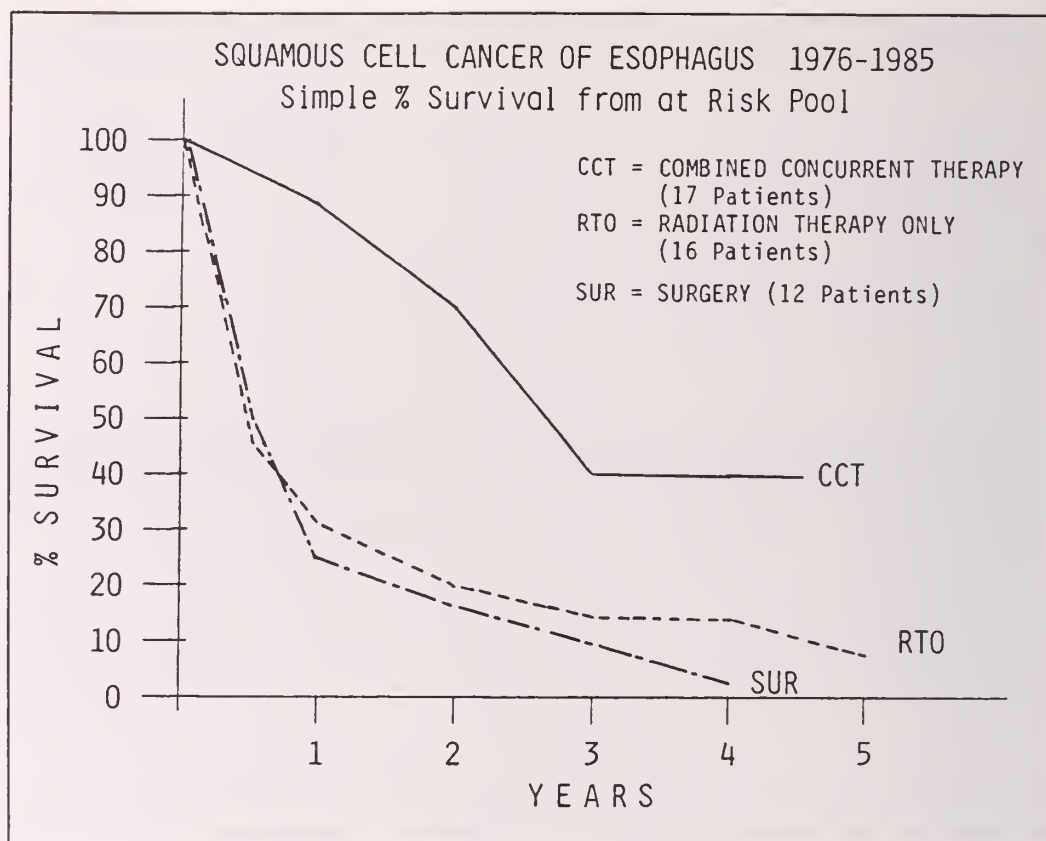


Figure 1.

tumor receives a dose of 5,600 rad with two 96-hour exposures to IV infusion of 5-FU.

From 1976 through 1985, ten patients with epidermoid carcinoma of the anal region were treated with this regimen. Eight of these ten patients are living with no evidence of disease as of follow-up in September 1986. This follow-up period ranges from nineteen to eighty months. Three of these patients had interstitial implantation in addition to external beam radiation therapy. For one of those patients, an extensive area of radiation necrosis developed following an interstitial implant. This required an abdominal perineal resection and two plastic procedures for repair. At the time of the abdominal perineal resection there was no residual tumor in the specimen. The patient had complete repair of the radiation defect and was living comfortably sixty-one months after treatment, free of any evidence of disease.

The second patient had no complications or adverse reactions to the implant, and the third patient was alive thirty months after treatment, with no evidence of recurrence of her carcinoma of the anus, but with a new and separate primary carcinoma in the lung. Two cases were not controlled by the treatment regimen. This resulted in the death

of one patient twenty-three months post-treatment. The other patient was living with known recurrent disease when last heard of at sixty months post-treatment.

Discussion

It is our impression that with close and careful follow-up, local failure can often be diagnosed early enough to be salvaged by a radical surgical procedure. The normal tissue tolerance of this form of therapy seems to be very similar to that for a radiation dose alone delivered at a 10% to 15% higher total dose. The addition of an implant, raising the total dose to 7,000 rad, did lead in one case to the complications described; however, the patient's problem with healing was compounded by rather severe vascular disease. The surgical wounds and grafts did not begin to heal satisfactorily until an obstructed iliac artery was surgically corrected. At that point healing was rapid and complete, and the patient remains tumor-free. The remainder of the patients maintained excellent sphincter function and had complete healing of perineal and anal skin reactions in a matter of a few weeks.

With similar results being found by others, and

SQUAMOUS CELL CANCER OF ESOPHAGUS 1976-1985

Simes-Zelen Technic Survival from Hazard Function

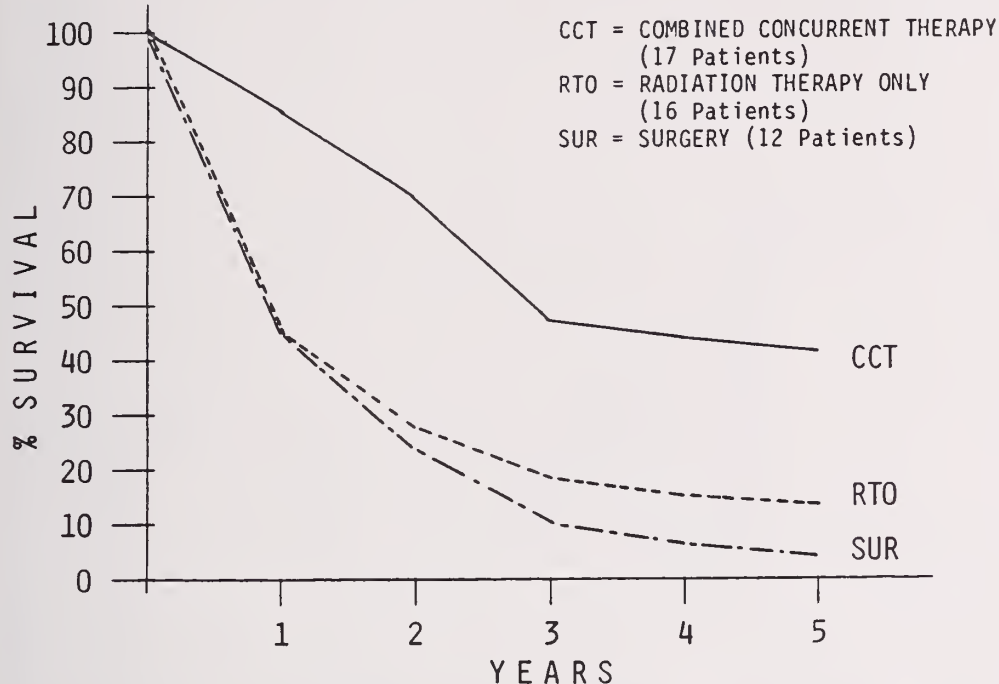


Figure 2.

in consideration of the rather poor prognosis for most epidermoid carcinomas of the esophagus, several authors^{3,7,8} attempted to apply such a treatment regimen to esophageal cancer. Eventually, Dr Sischy designed a protocol that was piloted and then accepted by the Eastern Cooperative Oncology Group as ECOG Protocol-1282. With our initial satisfactory results with squamous cell carcinoma of the anus, we entered into a similar project at about the same time.

From 1976 through 1985, a total of 89 cases of carcinoma of the esophagus were reported at Saint Francis Hospital. Of these 89 cases, 17 were treated with concurrent combined therapy similar to that used in the ECOG Protocol-1282. These were patients with biopsy-proven squamous cell carcinoma of the esophagus without evidence of distant metastases. They were not selected for early stage of disease or small lesions. Several of the lesions were considerably greater than five centimeters in extent, and at least two of the patients had total esophageal obstruction at the time of treatment.

This treatment consisted of external beam radiation therapy combined with concurrent 5-FU infusion chemotherapy. The radiation dose was delivered at 180 to 200 rad per day to a total dose of

from 5,400 to 6,200 rad. Many but not all of the patients received a single bolus intravenous injection of mitomycin-C on the first day of chemotherapy. As in the above described technique, two cycles of 5-FU infusion chemotherapy were given on Days 1 or 2, and again on Day 28.

The results of our study are presented in the attached figures. In Figure 1, we see a simple survival curve showing the percentage of patients alive out of the pool of patients at risk for each time increment. Nearly all of those patients who received surgery alone had died by the end of the fourth year. Likewise, there were very few survivors among those who received radiation therapy alone. Of the 17 patients who received the concurrent combined therapy, approximately 41% were alive at the end of five years and appeared to represent a stable population after the third year. This 40%, however, is a matter of two out of five patients at risk and is of limited statistical significance. We found that nearly all of the failures in treatment of cancer of the esophagus appeared by the end of two-and-a-half years.

Figure 2 demonstrates a similar survival curve, but one that is derived from the mathematics of a "hazard function." This is modeled after the technique of Simes, Zelen⁹ and represents a more

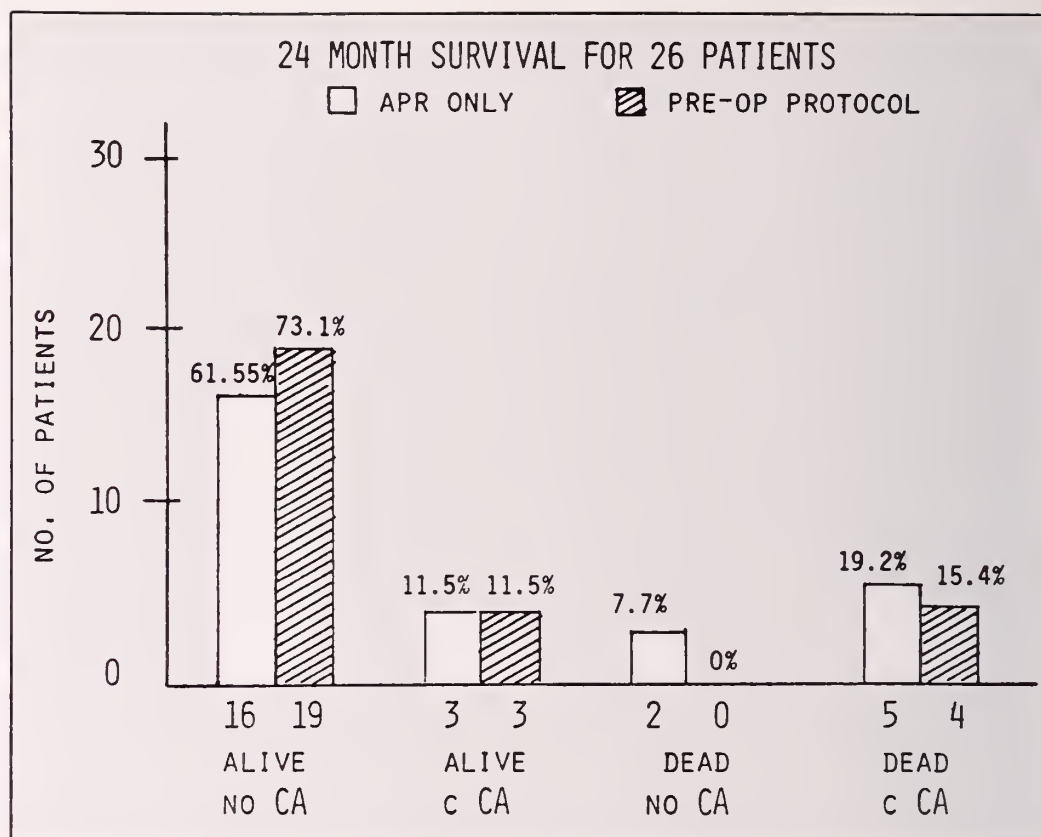


Figure 3.

statistically sophisticated method of analyzing the hazards of the tumor and the probabilities of survival. This curve is essentially superimposable on the other curve and once again suggests a relatively flat line after three years and the probability of some 40% or so of the patients surviving after being treated with concurrent combined therapy. Our analysis of the data shows that at two years 62% of the patients, living and dead, were free of esophageal recurrence. One-third of the patients, whether living or dead, had demonstrated a recurrence of the primary carcinoma.

The newest data available for comparison are those of Keane et al⁷ in 1985. They compared a single or

straight-through course of therapy, similar to this treatment, with a split course type of therapy (Table). It should be noted that their course of treatment included only one cycle of chemotherapy during the first week of treatment. The patients were treated for four weeks at a dose of 225 to 250 rad per day, which gives a dose biologically equivalent by time dose fraction factor (TDF) tables to a total of 5,000 rad to 6,000 rad at 180 rad per day. This is a dose range very similar to that used in our studies, although our patients received two cycles of chemotherapy. At two years their overall survival figures for the continuous course of therapy with concurrent 5-FU infusion was 48%. This is quite similar to our three-year experience of 41%. Likewise, they reported a local relapse-free rate of 73% at two years, not dissimilar to our 66%.

In looking at the curves, it would appear that surgery and radiation therapy performed very poorly indeed. In an effort to validate these curves, we reviewed the literature. Fortunately, a considerable amount of this work had been done by Earlam et al in 1980, in a series of articles that reviewed 122 papers in the literature covering 83,783 cases of cancer of the esophagus.^{10,11} They reported a 4%

Table. Comparison of Single Course to Split Course Therapy

		Split course (%)	Single course (%)
1 Year	Local relapse-free rate	29	73
	Survival	38	58
2 Years	Local relapse-free rate	29	73
	Survival	13	48

Keane et al, 1985

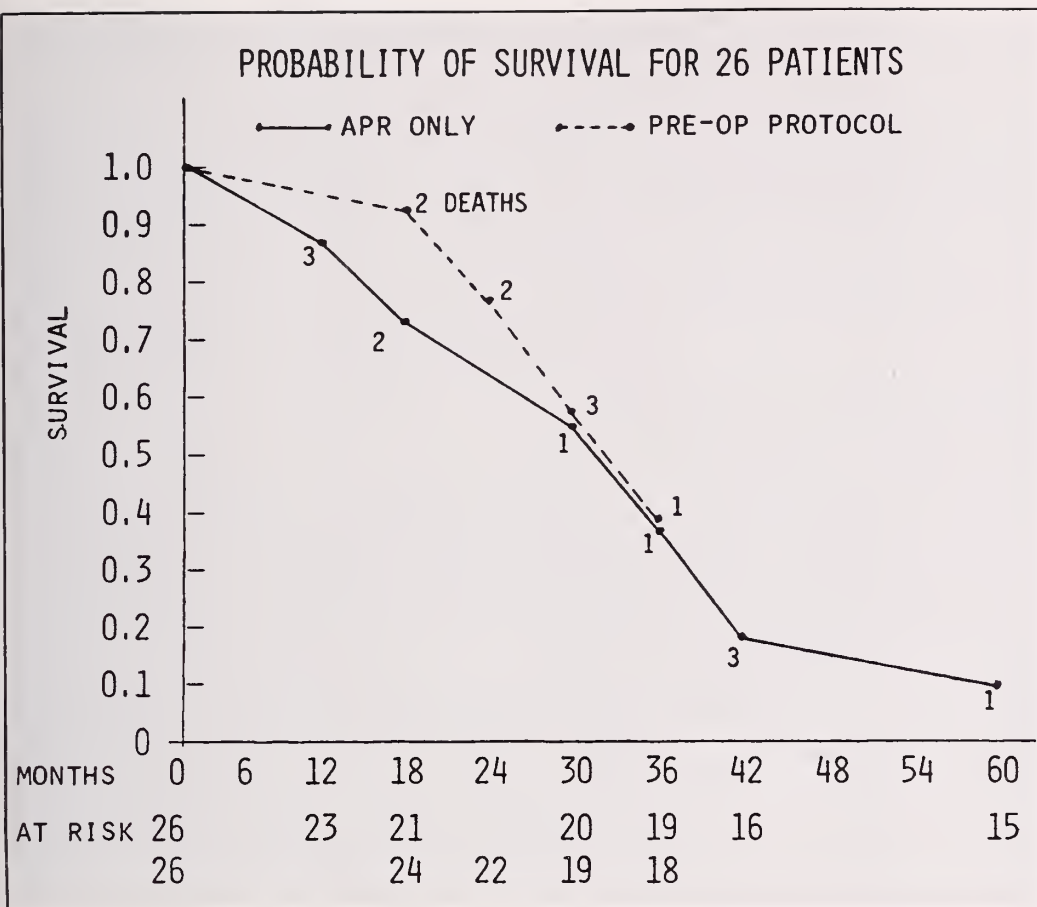


Figure 4.

five-year survival figure for surgery of cancer of the esophagus. In that group, a much smaller group of patients were seen who were able to undergo surgery and have apparently complete tumor resection. This group of patients had a five-year survival rate of 10%. In addition, the authors reported on a large group of patients undergoing radiation therapy for curative intent who showed a 6% five-year survival rate. In comparison, it appears that our curves are in keeping with the world experience at the five-year time frame.

With our initially encouraging results in two epidermoid carcinomas of the GI tract, it was thought perhaps this program might be effective in adenocarcinoma of the rectum. It was noted that adenocarcinoma of the rectum occurring relatively low in the rectum and requiring an abdominal-perineal resection for surgical management, has been most resistant to improvement in results over the past several years.⁴ In an effort to improve on this, radiation therapy had been used preoperatively, postoperatively, and in a combination of the two in the "sandwich technique." There are mixed reviews as to the results of such treatment.

Since the results from surgical management with abdominal-perineal resection are less than satisfac-

tory, we established a protocol at the Natalie Warren Bryant Cancer Center of Saint Francis Hospital for the treatment of such lesions. Patients with biopsy-proven adenocarcinoma of the rectum, whom the surgeon felt at the time of the initial examination would require an abdominal-perineal resection for cure, were accepted for preoperative treatment.

The patients underwent appropriate staging procedures and then were started on a course of radiation therapy with external beam supervoltage radiation to the entire pelvis through anterior/posterior fields or through a four-field technique, 160 rad per day, delivered to a total of 4,000 rad whole pelvis in twenty-five fractions over five weeks. On Day 2, the patients began a 96-hour infusion of 5-FU chemotherapy at 1,000 mg/M², which was repeated again on Day 28. In the initial phases of the study, a single bolus of ten milligrams of mitomycin-C/M² was given. This was later discontinued because it seemed to cause considerable bone marrow suppression and in our judgment, as well as that of others, may not be a necessary part of the combined program.

All patients finished the planned course of radiation therapy, although a few of them required rest breaks ranging from a few days up to two weeks

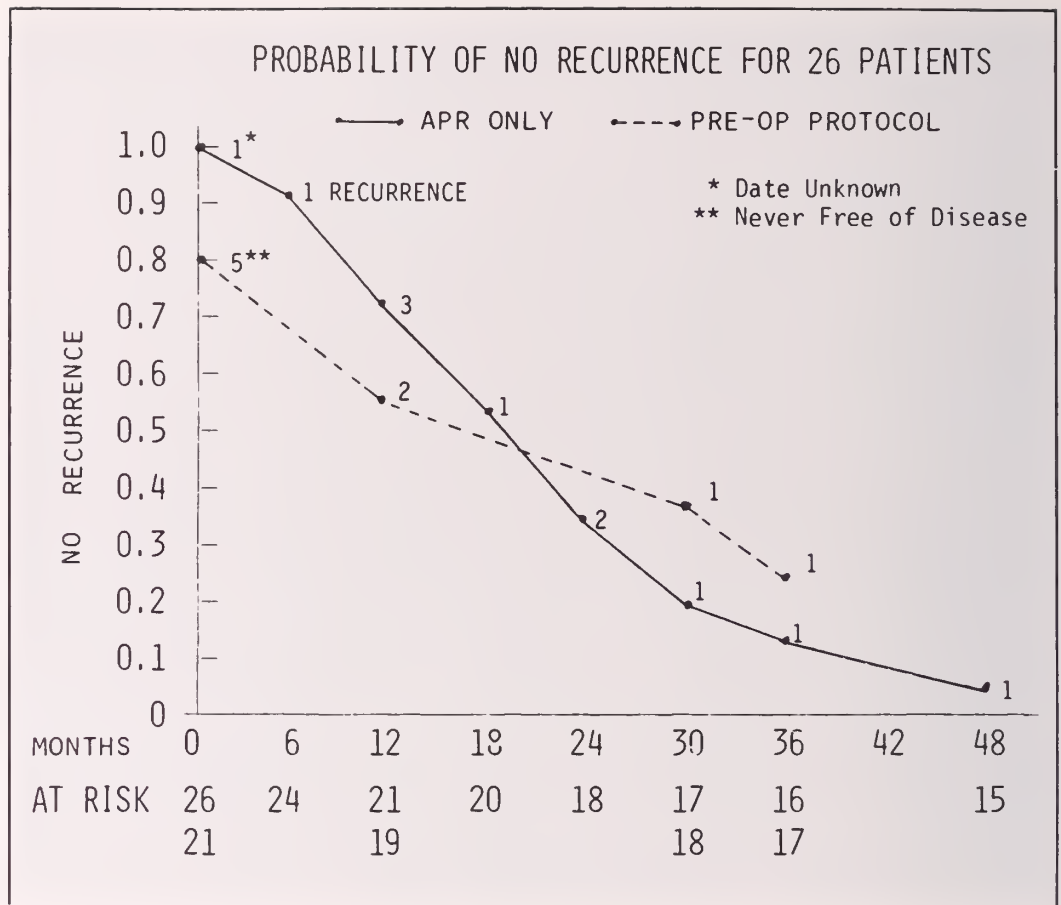


Figure 5.

due to skin reactions, especially of the perineum. The first 26 cases treated with this protocol were analyzed. The follow-up period was at least two years, and the patients were matched with 26 others who had similar disease and who underwent abdominal-perineal resection without preoperative treatment. The results are presented in Figures 3 through 5.

In reviewing the surgery performed after completion of the radiation and chemotherapy, we found that although all patients were thought to need an abdominal-perineal resection to begin with, only 62% had to undergo such an operation. Twenty-seven percent of the patients were "converted" to an anterior low resection that would leave the sphincter intact. These "conversions" were due to marked reduction in the size of the tumor and its local extent. One patient became clinically free of disease and refused to consider surgery. He has now been followed for two years with multiple endoscopies and remains tumor-free. Two patients were found at the time of surgery to have metastatic disease to the liver, and the definitive resection was not carried out.


In evaluating survival, a bar graph representation compares the number of patients alive without cancer, with cancer, and those dead without cancer

and dead with cancer. It appears from our evaluation that there is no significant difference between the group that had preoperative treatment and the group that did not have it. The final two figures are the probability of survival as a standard survival curve, showing no significant difference, and the probability of disease-free survival, again showing no significant difference between the two groups of patients.

From these results, there does not appear to be in our study any statistical significance between the group treated with the preoperative protocol and those treated with surgery alone. The clinical impression, as judged by skin reaction, diarrhea, and other side effects including cystitis, is that the patients received a dose equivalent to 5,000 to 5,400 rad in five to five and a half weeks. We did not feel that further evaluation of the radiation therapy dose would be practical because of the risk of increasing significant complications.

Conclusion

In summary, it is our opinion that concurrent combined therapy to include external beam radiation and 5-FU infusion, can and does play a favorable role

in the effective treatment of gastrointestinal malignancies of epidermoid origin, whether they occur in the esophagus or in the anal region. It does not appear to be effective in the treatment of adenocarcinoma of the rectum, and our experience with a limited number of cases of adenocarcinoma of the stomach and pancreas is equally unimpressive. We now therefore limit our definitive use of this treatment modality to epidermoid tumors. 

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The more things change . . .

One of the chief defects in our plan of education in this country is that we give too much attention to developing the memory and too little to developing the mind; we lay too much stress on acquiring knowledge and too little on the wise application of knowledge.

— William J. Mayo

Untimely Death: Suicide in Children and Adolescents

JAMES R. ALLEN, MD

Suicide today is the third leading cause of death among 15-to-24-year-olds, and the seventh among those aged 5 to 14 years. During the last two decades, the rate has tripled for 15-to-24-year-old white males, although it has decreased for all older age groups. This paper examines the etiology of suicide in children and adolescents, and outlines methods of intervention.

Every day, about 17 adolescents kill themselves. Suicide is now the third and, in some areas of the country, the second leading cause of death for 15-to-24-year-olds. During the past 20 years, the rate for the young white male has tripled, and this is probably an underestimate, for it does not include deaths classified as accidents.¹ Additionally, there may be as many as 150 to 200 attempts for every completed act.² Yet, however dramatic these figures appear, it should be remembered that adolescence is one of the physically healthiest periods in the life-cycle.

Although the suicide rate for adolescents and particularly for white males has increased, their rate is still lower than the rates for older groups, and most of this increase is associated with alcohol and drug

abuse. Indeed, the rates for older groups have actually decreased.

Suicide is the seventh leading cause of death in 5-to-14-year-olds. Although statistics for this group are hard to find, it appears that their suicide rate has remained constant for the past ten years. The National Center for Health Statistics tends not to classify suicide as a cause of death in children under 10 years of age on the basis that most children under that age do not understand the finality of death. Yet children as young as 2½ or 3 years old talk about wanting to kill themselves and engage in such intentionally suicidal behaviors as ingesting poisons, jumping from high places, and attempting to hang themselves. Several current observers, consequently, have suggested that it is not the child's concept of the finality of death that is important, but rather that he or she have some concept of death.

During the 1950s, suicide rates increased with each successive year. This pattern has changed. The graph of number of suicides plotted against age is now relatively flat for all age groups under 65 years. For women, the curve between 1950 and 1980 did not change: It is an inverted U, with the lowest suicide rates in the youngest and oldest groups.

Most adolescents in the United States who commit suicide kill themselves with firearms. (This is not the case in Europe, where firearms are less

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readily available.) Among adolescent boys, the popularity of this method is followed closely by hanging. In adolescent girls, self-poisoning, typically by over-the-counter (OTC) drugs, is the next most common method, although this is usually not successful. Children are more likely to jump from heights.

In the past few years, the news media have presented sensationalized, even romanticized reports of suicide by young people. Not infrequently, these reports suggest that such suicides are neither predictable nor preventable, and emphasize the cost of growing up in modern society. In reality, this is quite inaccurate. Suicide is not committed by normal adolescents, but is highly correlated with anticipatory anxiety, depressive syndromes, alcoholism, and drug dependency and, to a lesser extent, with histrionic and obsessive-compulsive behaviors, attention deficit disorders, and schizophrenia.³ If suicide were strongly correlated with stress, it would be more frequent among young blacks. In reality, 76% of all adolescent suicide victims are male, 90% white male. Yet, psychiatric illness alone is not sufficient, for most young people with psychiatric disorders do not kill themselves.

Risk Factors

Suicide is a behavior which develops out of several interdependent variables: (1) early childhood experiences and the child's responses to them; (2) affects such as depression and anticipatory anxiety; (3) current environmental stressors and interpersonal relationships; and (4) current ego functioning. In young people who are vulnerable, a balance of forces seems to exist which maintains a relatively unstable equilibrium between these forces. Shifts in this balance may occur suddenly. Consequently, suicidal episodes are usually transient.

Throughout life, these factors interact. For example, adolescents are more likely to respond to a current event with self-destructive behavior if they have previously suffered abuse, neglect, or loss. If abused as toddlers, they may provoke others to become angry and to hit them. Early memories and thoughts, re-experienced in current situations, will influence these young persons' current perceptions, emotions, and interpersonal relationships. In this multidimensional but volatile balance, suicide can suddenly appear as the best solution to their pain.

1. Early Life Experiences. Although there are relatively few studies exploring the relationship of

early life experiences to suicide in children, two groups need to be mentioned. First, there is considerable evidence to suggest the devastating effects of certain types of early loss. Stanley and Barter,⁴ for example, compared hospitalized suicidal and nonsuicidal patients and found that separation from parents when very young is a major discriminating factor. Using a Life Stress Inventory that categorized the life experiences of children at specific phases of development, Cohen-Sandler and colleagues⁵ found that suicidal children had experienced increasing

Suicide today is the third leading cause of death among 15-to-24-year-olds.

amounts of stress as they matured. Of these multiple stressors — separation from parents, divorce, remarriage, birth of a sibling, and the like — loss was the most important.

In an important study, Salk et al⁶ investigated 46 risk factors from prenatal, birth, and neonatal records of 52 adolescents who committed suicide before age 12 years and of two matched controls for each subject. Three specific factors were found to differentiate powerfully the suicide victims from the controls: (1) respiratory distress for more than one hour at birth; (2) chronic disease of the mother during pregnancy; and (3) absence of prenatal care before 20 weeks of pregnancy. These risk factors occurred alone in 81% of the suicide cases. What remains to be understood is exactly how these factors effect their influence, although one might hypothesize either that the child was unwanted or difficult to establish a relationship with, or that the mother was too depressed, ill, or burdened to do so.

Development of self-protection. Children's ability to maintain and preserve the intactness of their bodies and to develop the abilities that guide and protect them from dangerous activities develop out of their interactions with the important people in their environment. To protect themselves adequately, children need to develop the following functions: an ability to be self-assertive, an ability

to anticipate dangerous situations, positive self-esteem sufficient to feel that they are worth protecting, an ability to control impulses, and an ability to choose associates who will not jeopardize their existence. Above all, they must internalize the idea that they are of value and worthy of protection. For them to do this well, the environment needs to provide them protection from injury, freedom to express their emotions, opportunities to explore and play, and a structure that allows them to know what to expect.

Until recently, most clinicians did not believe children became depressed...

It has long been known that suicide tends to run in families. This has given rise to several hypotheses about the role of modeling and the intergenerational transmission of "hot topics" and behavioral patterns. More recently, however, biochemical evidence has brought to our attention the role of low levels of 5-hydroxyindolacetic acid (5-OHIAA) in cerebrospinal fluid. People with low levels of 5-OHIAA, which is believed to reflect central nervous system levels of serotonin, have a twenty-fold increased risk of committing suicide within one year, regardless of diagnosis. Therefore, those antidepressant medications which enhance serotonin functioning may be indicated in the treatment of suicidal risk, whether or not the person meets criteria for a major affective disorder.

2. Current Affect. Research over the past 20 years has demolished the myth that normal adolescence is marked by emotional extremes and behavioral turmoil. In reality, only transient, nondisabling mood changes and minor rebellion constitute the symptomatology of normal adolescence.

Depression is a major predisposing factor in the suicidal behavior of children and adolescents. In their studies of preadolescents, Pfeffer and colleagues⁷ found that depressions of the types classified by the *Third Diagnostic and Statistical*

Manual of the American Psychiatric Association (*DSM III-R*) as major affective disorders and adjustment disorders with depressed mood were correlated with suicidal behavior. Carlson and Cantwell⁸ found that intensity of depression is associated with the seriousness of suicidal ideation. In their study of children and adolescents, 63% of the depressed children were suicidal. However, 34% of the suicidal children were not depressed.

Among those not depressed, hostility, anticipatory anxiety, and antisocial features are prominent. In study after study, suicide is associated, in this age group, with antisocial behavior and interpersonal aggression. In later studies of preadolescents, Pfeffer⁹ concluded that there are at least two groups of suicidal young people. Members of the first group show good reality testing and defenses, but become depressed under the influence of extreme environmental stressors. Members of the second group are assaultive as well as suicidal, have distinct ego defects, exhibit episodes of rage, and mimic the suicidal behavior of their parents. Among these young people, the most common diagnosis is borderline personality, although younger children may present with a conduct disorder.

The San Diego Suicide Study and preliminary reports of the forthcoming Columbia study draw attention to the role of chemical abuse and dependency.¹⁰ Typically, parents and physicians know little about drug abuse which is common knowledge to the victim's friends. This problem had received little attention in previous studies, although Shafit et al¹¹ had reported that in their study 14 of the 20 suicide victims under the age of 20 years had frequently used nonprescription drugs or alcohol, as compared with only 5 of the 17 control subjects. Indeed, Miles¹² went so far as to speculate that drug usage might be the single most important factor in the increased suicide rate of youth.

How this association is to be interpreted is not clear. For some young people, alcohol and drugs may be used to escape the same problems that precipitate thoughts of suicide. If drugs are insufficient, then suicide may be considered. For others, drugs and alcohol may be used to signal distress. Still others seem bent on self-destruction on the installment plan.

Not a few young men inadvertently hang themselves while masturbating, apparently trying to utilize the effects of hypoxia to increase orgasmic pleasure. With the internal pressures of puberty and adolescence, it is not unusual for gender distur-

bances, which may have been relatively quiescent during latency, to reemerge accompanied by disturbing dysphoria and anomia. We do not know how many gender dysphoric youngsters are among adolescent suicide attempts, but if they do survive, these young people tend to emerge from a suicidal crisis with a transexual resolution to their dilemmas. Schizophrenics may respond to delusions or to hallucinations commanding them to kill themselves, or may kill themselves in hopes of escaping internal or projected tormentors. Children and adolescents

Very few young people commit suicide without some precipitating factor.

who have been abused, sexually or otherwise, are at increased risk, as are those who run away from home and teenage girls who become pregnant.

In preadolescence, intensity of depression is clearly related to severity of suicidal ideation, but is less clearly associated with suicidal attempts. Orbach and Glaubion¹³ reported that ideas about death differ in suicidal and nonsuicidal children: Suicidal children are more likely to believe in life after death, while aggressive and normal children emphasize the finality of death. In their study of 101 nonpatient and randomly selected normal preadolescents, Pfeffer et al¹⁴ found that 11.9% had suicidal ideation. Children with suicidal ideation differed from the nonsuicidal in being more preoccupied with death, having more recent and more frequent depressions, showing a greater tendency to use introjection as a defense mechanism, and more frequently having mothers who were suicidal.

Diagnosis of depression in children and adolescents. No topic in child psychiatry has been so extensively debated as that of the existence of affective disorders in childhood. Indeed, the very possibility of their existence has gained acceptance only during the last decade, although accurate clinical descriptions had been published since the sixties. A major problem in the study of depression in childhood is evident in the very terminology used

to designate the study topic: Which is studied, "depression in childhood" or "childhood depression"? These two competing conceptual models — the latter a developmental model which suggests that depression manifests differently at different ages and the former, a model based on studies of adult patients, have very different implications. For the moment, the field has opted for the adult model, as reflected in the current *DSM III-R*.

Until recently, most clinicians did not believe children became depressed because they lacked a fully structured superego. More recent formulations, however, have conceptualized depression as a basic negative affect which arises when individuals have suffered a loss of a former state of well-being and have been unable to mobilize themselves to respond effectively to this change. Recently there has been validation of the existence of a chronic, relatively low-grade depression among school-age children and adolescents. In *DSM III-R*, this condition is labeled *dysthymic disorder*. We have also begun to recognize endogenous and psychotic forms of affective disorder in children. Frank bipolar illness occurs in adolescence, but has been less convincingly described in prepuberty, although it does occur. It would seem that over half the adolescents with bipolar disorder do not present with typical manic symptomatology, but rather present less easily diagnosable forms of the disorder.

Prospective studies of uniformly diagnosed samples of depressed children and adolescents have been initiated only in the last decade. However, the evidence is now quite strong that the course is frequently chronic and persistent, with accumulating and widespread psychosocial and functional deficits as well as persistent psychiatric difficulties. Indeed, for young people who have a dysthymic disorder or major depression, age of onset is significantly and inversely related to the rate of recovery.⁴

If we consider depression a primary affect, the major question then becomes how, at each developmental stage, a young person's limitations and abilities impose a characteristic picture on the expression of the dysphoria. Younger latency-age children, for example, accept experience at face value. Thus, one would not expect them to complain of low self-esteem or feelings of guilt. As children approach puberty, however, they will show a greater cognitive component, evidenced in lowered self-esteem and feelings of guilt. Often, these children will deal with frustrating situations by avoidance or by clinging to parental figures — and thus

deprive themselves of opportunities to master successfully the developmental tasks of latency. It is only with adolescence that a young person develops an adult's sense of time, and so it is only with adolescence that depressive symptomatology includes the hopelessness and despair typical of adult depressions.

Whatever the precipitants for adolescents who are suicidally depressed, we usually find them ill equipped to deal with life. Many have not learned to find meaning and gratification from their own activities. They are unable to direct and structure their lives, making them vulnerable to finding solace in a cult or to remaining pathologically dependent on their family, even if it is no longer satisfying. Others carry with them unrealistic moral expectations that were engrained during earlier years but which they are unable, without great anxiety and guilt, to modify into more realistic and obtainable standards.

3. Environmental Stressors. Very few young people — perhaps less than 10% — commit suicide without some precipitating factor. Frequently they do so during the time interval between discovering they are in trouble and the consequent punishment, that is, during a state of anticipatory distress. Chronic family disorganization is common, and the young person's suicidal behavior typically is precipitated by a family crisis. Threat of punishment is an important precipitant, as is an unhappy love affair.

Talk of suicide by parents, parental suicide attempts, and a family history of affective disorders, violence, and physical abuse are common.^{15,16} However, there is no straightforward relationship. In some families, suicides, suicide attempts, and child abuse seem symptomatic of a poor marriage. In others, high rates of child abuse and parental suicide attempts signify the parents' low threshold for aggression. In still others, there may be a genetic predisposition to low levels of serotonin in the brain. In general, correlations suggest that children at risk grow up in families where violence is common. Relationships with their parents are characterized by episodes of stress and conflict. They live in a world which is unpredictable, with trust in parents unlikely, and they make suicide attempts at times of disagreement, apparently to escape intolerable feelings of pain.

4. Ego Functioning and Escape from Unbearable Pain. During a suicidal crisis, drastic changes

seem to occur in a person's cognitive skills, memories of being loved, reality testing, ability to regulate mood, and impulse control. Impulses that are usually unconscious find expression, identifications become intensified, judgment is impaired, and awareness of one's immediate situation is diminished. This cluster of changes results from regression in ego functioning secondary to current stressors. Suicide may seem the only solution to and escape from intolerable pain.

Assessment

An aggressive approach to prevention, early diagnosis, and treatment seems mandatory if we are to decrease the frequency of suicide.

First, we need to counter the myth that normal teenagers take their lives without warning. Most of these young people are troubled, and they manifest signs and symptoms of this. Second, people called upon to assess teenagers should be alert for evidence of underlying psychiatric disturbance. Probably 75% of adolescents who attempt suicide have communicated their intent prior to the event, perhaps more frequently to coaches and friends than to parents. Unfortunately, these confidants often fail to protect the suicidal person and join in a conspiracy of silence.

Appropriate treatment depends on the nature and seriousness of the problem — and this cannot be determined without thorough physical, psychiatric, and sociocultural evaluations. Assessment of suicide risk should be part of every child and adolescent psychiatric examination, and needs to be done by the pediatrician or family physician whenever he or she suspects its presence. Parents of children who suffer from depression and somatic complaints are much more likely to take them to pediatricians or family practitioners than to mental-health professionals.

Assessment of intent, lethality, and method is mandatory, and young persons and their families' responses must be evaluated in terms of what is said nonverbally as well as verbally. In this era of television, even young children know the word *suicide* and are very rarely upset when asked about it. When they do become upset, it may be that they do, in fact, harbor thoughts of suicide. When they deny suicidal ideation, moderately depressed children are at risk for suicide, just as depressed adults who deny similar thinking. Unfortunately, the parents of children who have suicidal ideation or who make suicide attempts often do not want to recognize this fact. Such denial is often a major hurdle in the

clinical management of these children, and may seriously impair such simple but important steps as removing potentially lethal methods.

Distress signals or indicators of possible increased suicide risk are as follows:

Changes in Mood

- Anticipatory anxiety
- Expression of hopelessness, doom, or emptiness
- Explosive rages
- Insomnia or excessive sleeping
- Poor appetite
- Dramatic highs and lows
- Feelings of already being dead

Changes in Behavior

- Drug and alcohol abuse
- Physical violence
- Disposal of possessions
- Decline in school performance
- Alienation from family and friends
- Accident proneness
- Talk, letters, or poems with suicidal content
- Increasingly frequent accidents
- Loss of or absence of interpersonal ties

Changes in Thinking

- Preoccupation with death
- Impaired concentration
- Shortened attention span

Life Events

- Death of family member or friend, especially by suicide
- Loss of peer relationships or other disappointments the adolescent considers major
- Public shame or its threat
- Parental separation or divorce
- Chronic illness
- Adolescent pregnancy or abortion

Other

- Male (5 times more boys commit suicide than girls)
- Native American
- Previous suicide attempt (about one-third of adolescent suicides)
- Hallucinations commanding the young person to commit suicide
- Media romanticization
- Religious beliefs
- Lack of permission to live
- Family history of suicide
- Significant date, eg, the anniversary of the death of a friend or relative

Of these, the most important seem to be:

1. Suicide of a family member
2. Chemical abuse
3. Antisocial behavior
4. Interpersonal aggression
5. Previous attempt
6. Major depression.

Four groups seem at particular risk:

1. Aggressive, impulsive adolescents with a long history of problem behavior and school difficulties. Drug and alcohol abuse and depression is common among these young people.
2. Anxious, perfectionistic adolescents who do well in school but have high levels of anxiety. This group represents a significant minority. They become suicidal before tests or anticipated moves from home.
3. Psychotic adolescents, particularly those with bipolar disorder.
4. Those in acute anticipatory anxiety, involving public shame or punishment.

It should be noted, however, that these signs and symptoms occur in a number of conditions, and no single one is pathognomonic of suicide. The following mnemonic, SAD CHILDREN, adapted from a protocol developed at the University of New Mexico,¹⁷ is a useful reminder of factors important in evaluating suicidal potential in children and adolescents.

S—Support systems

A—Alcohol abuse

D—Depression

C—Communication

H—Hostility

I—Impulsivity

L—Lethality

D—Demography

R—Recent events

E—Epidemiology

N—No hope

Although not all suicidal children are depressed, a significant number of adolescent suicide attempts are made by young people who are depressed. Consequently, early diagnosis and treatment of depression is an important intervention. Reliable data for younger children are not available; however, it is important for the clinician to be aware of diagnostic criteria for childhood depression.

The *DSM III-R* diagnostic criteria have not been modified for children. However, two other diagnostic systems have — Poznanski's¹⁸ and Weinberg's.¹⁹ All require the presence of dysphoric mood, although *DSM III-R* permits the substitution of irritability or a pervasive anhedonia. Both Weinberg¹⁹ and Poznanski¹⁸ permit the use of nonverbal manifestations of depressive affect (Fig). Although the three groups have different requirements for the duration of the dysphoria, this is rarely of significance

Educational efforts in regard to suicide... frequently run the danger of becoming "how-to" guides.

clinically because these children have usually been depressed for months before they are seen. In general, the Weinberg criteria are the least exclusive. Some children diagnosed as depressed using this system would not be so diagnosed under the others.

Young children vary greatly in their ability to perceive their own depression. One of their most characteristic features is anhedonia. This is particularly startling because fun is generally assumed by adults to be an integral part of a child's life. However, in depressed children, boredom, apathy, or irritability are common. Viewing television becomes simply staring at the screen.

Children lack an abstract concept of self until they are between 6 and 9 years of age. However, they will describe themselves in negative terms such as "stupid" or collect derogatory names given them by peers. Unlike normal children, depressed children often feel tired, and will even take an afternoon nap voluntarily. They usually retain the capacity for peer relationships, but frequently they turn down the opportunity. They do report insomnia, especially problems in going to sleep, of which their parents may be unaware, but rarely will they admit to loss of appetite, even when they have lost weight.

The seriousness of suicide intent can be ascertained by determining the young person's plan, the method intended, the purpose of the act, and his or

her prior adjustment, as well as the family structure and reaction. Hospitalization is not always necessary but is always legitimate.

Treatment

Proper treatment obviously depends on the assessment of the young persons, their family, and their social network. However, various treatment stages can be delineated.

1. Crisis Intervention. Something needs to be done at once in order to keep the patient alive until the suicidal crisis is over, and to reduce his or her perturbation. This may include hospitalization, round-the-clock babysitting, mobilization of his or her social-support network, and a chance to ventilate — all accompanied by strong verbal and nonverbal messages to "LIVE," including removal of the intended method of suicide. Since suicide seems associated with perturbation, perceptual and cognitive restriction, pain, and stress, these are the factors the clinician needs to address. "What would it take to keep you alive?" and "Let me help you think of alternatives" are useful statements. A Goulding-type "no-suicide" contract is useful diagnostically and therapeutically,²⁰ as are written plans for handling situations of crisis.

2. Amelioration of Underlying Problems. Once the immediate crisis is over, underlying problems need to be addressed. The most common problems are:

- (a) Chemical abuse
- (b) Low self-esteem
- (c) Loss of, or lack of social support
- (d) Feelings of helplessness
- (e) Feelings of hopelessness
- (f) Mourning
- (g) Lack of sense of self-preservation and protection
- (h) Parental indifference or inability to empathize with or support the adolescent's sense of loss or diminished self-esteem
- (i) Narrowed thinking in terms of options, and poor problem solving

3. Treatment of Associated Medical or Psychiatric Conditions. Of these, the most common conditions are antisocial behavior, chemical dependency, and depression. Each young person's problems need to be dealt with in their own right, utilizing the therapeutic armamentarium available — crisis

Diagnostic Criteria for Major Affective Disorders in Children

Poznanski ¹⁸ (1981)	DSM III-R (1986)	Weinberg ¹⁹ (1973)
Depressed mood, behavior, or appearance	Dysphoric or irritable mood and loss of interest in almost all usual activities	Dysphoric mood <i>and</i> self-deprecatory ideation
AND	AND	AND
Four or more of the following:	Three of the following:	Two of the following:
	Poor appetite, weight loss, or increased appetite	Unusual changes in appetite and/or weight
Hypoactivity	Psychomotor agitation or retardation	
Anhedonia	Loss of pleasure	
Lowered self-esteem, pathological guilt	Feelings of worthlessness or excessive guilt	
Difficulty with school work	Decreased ability to think or concentrate, or indecisiveness.	Change in school performance, change in attitude toward school
Morbid ideation, suicidal ideation	Recurrent thoughts of death or suicide	
		Somatic complaints, aggressive behavior
Complaints of fatigue	Loss of energy, fatigue	Loss of usual energy
Difficulty with sleep	Insomnia or hypersomnia	Sleep disturbance
Social withdrawal		Diminished socialization
DURATION: 1 month	DURATION: 2 weeks or more	DURATION: 1 month

intervention, individual and family therapy, social-skills training, assertiveness training, psychopharmacology, and case management.

Puig-Antich and associates²¹ have shown that a young person's recovery from a major depressive disorder is often not accompanied by full improvement in all aspects of psychosocial functioning but may lead to long-term social incapacities. These will not be improved through the prescription of antidepressants alone.

Ironically, tricyclic antidepressants, the medications most commonly used to treat depression, are also the medications most commonly used to overdose. Frequently, however, the suicidal adolescent takes the imipramine prescribed for his mother's depression or his younger brother's enuresis. Young people are more susceptible to the cardiotoxic effects of tricyclics than are adults, so their use in children under 12 years of age is generally not recommended by the manufacturers. A number of older studies reported the efficiency of tricyclics and monoamine oxidase (MAO) inhibitors in adolescents, but more recent and more methodologically sound studies report mixed results. Perhaps

the reason for this rather surprising finding may be found in the relationship between total tricyclic plasma levels and therapeutic response, and to changes in sex hormone secretion, especially estrogen. In general these medications do seem more effective in the depressed prepubertal child than in the adolescent. However, close monitoring, including initial electroencephalograms and serial electrocardiograms, is mandatory.

4. Establishment of a System to Monitor Future Problems and Correct Them. The goals of this stage of treatment are to decrease suicidal risk factors and the young person's vulnerability to repeated suicidal crises, and to enhance those factors which will protect him or her against future suicidal crisis.

To date, follow-up studies of depressed children have been minimal, but the results strongly suggest that these children need to be followed very closely. Kovacs and her associates²² have reported that the average length of episodes of dysthymic disorder is 68 weeks, in contrast to that of major depressive disorders (32 weeks) and adjustment disorder with

depressed mood (25 weeks). Dysthymic disorders are associated with a vulnerability to a major depressive disorder. The cumulative recovery rates for dysthymic disorder increase linearly with time. In the first year only 5% of these children recover. Major affective disorders may remit satisfactorily on their own, but at the end of one year the recovery rate is still only 55%. In contrast, 90% of children with adjustment disorders recover within one year. Thus, it seems that children with initial episodes of depression are at risk for recurrent and chronic depressive symptomatology. Consequently, they are also chronically at high risk for suicidal behavior.

Prevention

Obviously, the best way to treat suicide is to prevent it. However, this is notoriously difficult to do, and the efficacy of attempts is difficult to prove. Traditional mental-health approaches to suicide have been based on the idea that suicide is primarily a problem of older depressed men. This is no longer valid. Possibly effective interventions, however, fall into four major areas.

In studying the increase in adolescent suicidal behavior in the European Economic Community during the past two decades, Diekstra²² attributed the current epidemic to three groups of factors: (1) socio-economic and cultural conditions, (2) a specific problem-solving behavior repertoire, and (3) attitudes toward suicide.

1. Socio-Cultural Factors. Suicidal behavior is a response to certain situations learned directly by practice, or vicariously through the observation of others. The proportion of all suicides by firearms in the United States increased in all age groups from 1950 through the 1970s and has continued to climb for young people in the 10-to-19-years age group. Half the total suicides in the 1930s were by firearms. In the 1980s, firearms were responsible for two-thirds. This suggests its own remediation.

Educational efforts in regard to suicide and drug abuse frequently run the danger of becoming "how-to" guides. In February 1985, for example, ABC televised *Surviving*, a made-for-television movie concerning the effects of adolescent suicides on the surviving parents. In Waterbury, Connecticut,¹⁵ 14 patients were admitted for overdose during the two weeks following the broadcast, imitating the suicide depicted in the movie, as compared with four suicides in January, and four the previous February.²³ Suicide

clusters are not reportable, so there is no way to know whether they are increasing.

2. Modification of Developmental Interferences. In this category we can place early training in parenting skills, marital counseling, early diagnosis, treatment of parents with psychiatric problems, and teaching of problem-solving skills in the public schools. The early diagnosis and treatment of a depressed parent is secondary prevention for the parent, but perhaps more importantly, primary prevention for the young person.

People are consistent with themselves. Therefore, it behooves the clinician to look at how patients handled previous episodes of pain and perturbation, and their earlier efforts to escape them. Other things being equal, patients are likely to repeat their patterns of response.

3. Availability of Crisis Intervention Service and Recognition of and Intervention with High-Risk Infants and Children. There has been a recent blossoming of programs to educate school children in how to recognize signs of depression and suicide in themselves and in others, and how to find the treatment resources available in their community. Certain groups of teenagers seem at high risk for suicide. These include children and adolescents who have run away from home or who have been abused, and teenage girls who have become pregnant.¹⁵ Studies of these groups indicate that at least one-third have made or will make a suicide attempt. Children of parents with affective disorders are also a high-risk group.


An effective community-based approach should include the following:

- (a) The development of a community plan before a crisis arises
- (b) Identification of young people at risk
- (c) Identification of community resources and dissemination of this information
- (d) Identification of one community spokesperson
- (e) The avoidance of romanticization of suicides through such well-meaning but ill-advised activities as graduation ceremonies dedicated to the dead

Summary

Suicide is a complex behavior that develops out of several interdependent variables: (1) early childhood experiences and the child's responses to them,

including development of the ability to take care of one's self; (2) affects such as depression, anger, and anticipatory anxiety; (3) current ego functioning; and (4) environmental stressors and interpersonal relationships.

There are many suicidally depressed children and adolescents who are not involved in mental-health systems, but who may be brought to their family physician or pediatrician. Such behavior should be taken seriously, for the condition can be treated. However, the goal of the Department of Health and Human Services to reduce the suicide rate in the young to 11 per 100,000 by 1990 is, unfortunately, probably unrealistic. 

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Coming in January . . .

Scheduled for publication next month is the report entitled "Oklahoma State Department of Health AIDS Task Force Recommendations to Date." Issued March 3, 1987, the lengthy document represents an important consensus of expert opinion on AIDS in Oklahoma.

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Alzheimer's Disease: A Public Health Concern

Few chronic diseases have as profound an impact on society, patients, and their families and friends as does Alzheimer's disease. Alzheimer's is recognized as a disease that strikes two — the patient and the caregiver.

Because Alzheimer's disease is largely a disease of old age, the demographic changes in the United States have resulted in increasing numbers of people at risk for developing the disease. In Oklahoma, the average life expectancy after reaching 65 years of age is 86, which exceeds the US average by six years. Although good epidemiologic data from the US and Oklahoma are lacking, the prevalence of severe dementia in the 65 years and older population ranges from 1.3% to 6.2%.

Two-thirds of all victims are cared for at home. The family or caregiver must witness the gradual deterioration of the loved one's intellect, memory, and personal functioning, until that individual commands total care. The needs of the ill or frail parent/person with Alzheimer's may create undue demands on their spouse or children's time, energy, money, and emotional support, which can result in increased health problems for caregivers.

Social and health care services for these patients and their families are often fragmented. Many times services are unavailable. The sad fact is most families lack the time, energy, or knowledge for coordination of services.

The Eldercare Program sponsored by the Oklahoma State Department of Health provides management of health care and social services for the frail, at-risk elderly in 37 counties in Oklahoma. If you treat a family with an Alzheimer's patient, and the family is in need of respite care coordination, contact the Eldercare Program at (405) 271-4072 for assistance.



DISEASE	September 1987	TOTAL TO DATE		
		This Year	Last Year	5 Yr. Avg.
AMEBIASIS	0	8	7	9
CAMPYLOBACTER INECTIONS	44	207	210	—
ENCEPHALITIS, INEECTIOUS	4	19	19	25
GIARDIA INECTIONS	27	149	168	—
GONORRHEA (Use ODH Form 228)	886	7661	9496	10235
HAEMOPHILUS INFLUENZAE INVASIVE DISEASE	10	122	170	—
HEPATITIS A	21	202	271	377
HEPATITIS B	21	184	151	188
HEPATITIS, NON-A NON-B	4	33	46	—
HEPATITIS UNSPECIFIED	1	24	33	104
MEASLES (RUBEOLA)	0	3	39	15
MENINGITIS, ASEPTIC	15	132	100	143
MENINGITIS, BACTERIAL (non-meningococcal, non H. Influenzae)	3	28	55	48
MENINGOCOCCAL INECTIONS	1	18	21	23
PERTUSSIS	18	125	104	149
RABIES (Animal)	3	31	53	95
ROCKY MOUNTAIN SPOTTED FEVER	6	80	82	114
RUBELLA	0	5	0	1
SALMONELLA INECTIONS	101	354	367	337
SHIGELLA INECTIONS	15	126	166	210
SYPHILIS (Use ODH Form 228)	30	129	115	142
TETANUS	0	1	1	1
TUBERCULOSIS	14	173	191	194
TULAREMIA	4	24	9	18
TYPHOID FEVER	1	4	1	2

Diseases of Low Frequency	Total to Date This Year
ACQUIRED IMMUNE DEEICIENCY SYNDROME	174
BRUCELLOSIS	5
LEGIONNAIRES DISEASE	20
MALARIA	3
REYE SYNDROME	0
TOXIC SHOCK SYNDROME	14

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*Legalizing a common practice***Licensing board explains new SMD title to critics**

Criticism of the newly authorized SMD (supervised medical doctor) designation for physicians stems from a lack of understanding of Oklahoma's medical practice laws, according to the State Board of Medical Licensure and Supervision.

In reply to numerous inquiries about the law, the board (formerly the State Board of Medical Examiners) has issued a letter explaining the history and rationale of the law.

The new statute bridges a gap in a 1923 state law which was clearly intended to allow the citizens of Oklahoma to distinguish licensed from unlicensed medical doctors, says the board. The law simply denied the right of use of *Doctor* and *MD* to all but those allopathic physicians who were fully licensed.



Mary Anne McCaffree, MD, Oklahoma City, addresses the October 14 meeting of the OSMA Council on Public and Mental Health. Dr McCaffree, a pediatrician, heads the 1987-88 Perinatal Task Force.

Because one of the requirements for state licensure is the satisfactory completion of one year of postgraduate study, interns or first-year residents (PGY1s), for example, who called themselves "Doctor" or "MD" were, in fact, violating the law.

So, too, were the faculty and staff physicians who trained them, the letter continues, for the law also prohibited the promotion of the practice of medicine by an unlicensed individual.

Furthermore, because those PGY1s were not licensed, they did not fall under the jurisdiction of the board, the state's regulatory agency for the supervision of medical doctors. Law enforcement was left solely in the hands of local law enforcement agencies.

"The fact that this portion of the law was not enforced does not alter its status," the board notes, "and we cannot endorse the violation of any portion of the laws we are sworn to uphold, regardless of the frequency of such violations."

The new law states, in part, "All persons holding the degree of Doctor of Medicine and using that degree as a criterion for their employment, continuing education, or professional training but who have not obtained or maintained regular licensure will be under the jurisdiction of the board and may be designated as Supervised Medical Doctors (SMD).

"Such persons employing the term Doctor or the suffix MD in connection with their name will in all circumstances clearly designate their supervised status.

"The manner of designation may be determined as prescribed by the board."

Copies of the board's letter explaining the law, as well as an explanation of the meaning and significance of the SMD title, are available on request from the State Board of Medical Licensure and Supervision, 5104 North Francis, Suite C, PO Box 18256, Oklahoma City, OK 73154-0256, (405) 848-6841. □

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Declining US teen pregnancy rate still higher than other nations

Pregnancy and birth rates among US teenagers declined between 1974 and 1983 but remain considerably higher than in other developed countries, says a new study.

The study by Barbara J. Maciak, PhD, of the Centers for Disease Control (CDC), Atlanta, and colleagues says the pregnancy rate among females aged 15 to 19 years increased 8.2% between 1974 and 1980 (the actual number of pregnancies increased 10.5% in the late 1970s). Between 1980 and 1983, the rate fell from 88.6 to 87.1 pregnancies per 1,000 teens, and the actual number of pregnancies declined by 10.8%.

Despite the decline, the pregnancy rate for women aged 18 and 19 years was 2.3 times greater than for females aged 15 to 17 over the time period studied, the report finds. During each year, 18% to 20% of sexually experienced teenagers become pregnant, it notes.

Birth rates among teens declined 9.2% between 1974 and 1980 and continued to decline after 1980 by 2.3% (from 58.4 to 51.8 births per 1,000). The drop from 1974 to 1980, the report says, "was related to the large increase in the percentage of teenage pregnancies ending in abortion." Although the pregnancy rate from 1980 to 1983 declined, the percentage of teen-age abortions remained constant. So the decline in the teenage birth rate from 1980 to 1983 "has been related to the overall decline in teenage pregnancies," the study adds.

Despite recent progress in reducing teen pregnancy and birth rates, pregnancy and childbearing among teens in the US remains a serious problem, the report concludes. "Continued efforts aimed both at delaying early sexual experience among teens and encouraging the use of contraception among sexually active teens are necessary to further reduce teenage pregnancy and birth rates in this country."

The report appeared in the October 16 issue of the *Journal of the American Medical Association*. □

**January is
Birth Defects Prevention Month**

ASIM elects Oklahoma physicians to presidency and trusteeship

An Oklahoma doctor has been elected president of the American Society of Internal Medicine, and one of his state colleagues will serve on the ASIM Board of Trustees.

William R. Smith, MD, Enid, was elected president of the ASIM at the society's 31st Annual Meeting in Washington, DC, in October. Serving with him as a member of the Board of Trustees will be M. Boyd Shook, MD, Oklahoma City.

As president, Dr Smith will have overall responsibility for ASIM's operations, activities, and policymaking. He will preside over Board of Trustees meetings and serve as the society's chief spokesperson.

Dr Smith, long active in Oklahoma medicine, is a past president of both the Oklahoma Society of Internal Medicine and the Garfield County Medical Society. Currently he sits on the Board of Trustees of the Oklahoma Medical Research Foundation. He is a graduate of the University of Oklahoma, where he is currently an associate clinical professor of medicine.

A Fellow of the American College of Physicians,

Dr Smith has been board certified in internal medicine since 1967.

Dr Shook, new ASIM trustee, is vice-president of both the Oklahoma County Medical Society and the Oklahoma Society of Clinical Oncology. He is president of the Oklahoma Foundation for Peer Review and past president of the Oklahoma Society of Internal Medicine.

A graduate of George Washington University School of Medicine, Dr Shook is board certified in internal medicine. He was a clinical assistant professor of medicine at the University of Oklahoma from 1975 to 1986.

A subspecialist in hematology and oncology, Dr Shook is active in the American Society of Hematology, the American Thoracic Society, the American Federation for Clinical Research, and the American College of Physicians.

Serum cholesterol also important

'Lower the better' may not be true in blood pressure control

In hypertension patients, there appears to be a point below which further blood pressure (BP) reduction offers no additional treatment benefit, concludes a recent study.

"To improve the prognostic outlook in hypertensives we must improve all our risk factor interventions, considering the total cardiovascular risk profile," say Ola Samuelsson, MD, PhD, of the University of Goteberg, Sweden, and colleagues. "Hence, rather than further lowering our goal BP, our first step would be to more effectively treat elevated serum cholesterol levels . . . and to enhance our efforts to improve the entire life-style."

The study looked at the relationship between cardiovascular disease (CVD) morbidity and control of blood pressure and serum cholesterol in 686 treated, middle-aged hypertensive men followed for 12 years. "Analyses of CVD morbidity in relationship to changes in BP and serum cholesterol levels clearly showed that a combined reduction of both risk factors was necessary to achieve a substantial reduction in morbidity," it reports.

(continued)

March 31, 1988, deadline for payment of OSMA, AMA dues

Oklahoma physicians by now should have received notices for their county, state, and American Medical Association dues. Notices were mailed the first week in November.

Because Oklahoma is a unified state, physicians receive a ten percent reduction in AMA dues.

Yearly dues, which include the AMA discount, are as follows:

AMA	\$337.00
OSMA	210.00
AMA First Year Practice	168.00
OSMA First Year Practice	105.00
AMA Second Year Practice	281.00
AMA Resident/Intern	45.00
OSMA Resident/Intern	10.00

Payment deadline is March 31, 1988.

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Blood pressure (continued)

The authors report a significant association between total CVD morbidity during the last nine years of follow-up and the relative reduction in cholesterol levels during the first three years. The relative degree of BP reduction, however, showed no association with reduced CVD risk. "If serum cholesterol levels remained unchanged or even increased, the effect of BP reduction was small, whereas a substantial reduction in both risk factors produced a substantial reduction in CVD and (coronary heart disease) morbidity," they note.

"Surprisingly, for mean in-study systolic and diastolic BP there seemed to be a level (about 150/85) below which further reduction of BP had no additional benefit from treatment," the study concludes. "Thus the expression 'the lower BP, the better' does not seem to be true in treated hypertension."

The report appeared in the October 2 issue of the *Journal of the American Medical Association*. 



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AIDS: Sammons urges 'informed caution rather than hysteria'

Almost half of American adults believe it is very likely AIDS will infect and kill a large share of the population, according to an American Medical Association survey on attitudes towards AIDS-related questions.

In addition to the 48% who believed it was "very likely," 32% believed it was "possible" that AIDS will infect and kill a large share (the survey did not define "a large share") of the population. The survey of 601 adults, questioned in July 1987, also showed that 17% believed such a health impact by AIDS was "not likely." Fifty-six percent of the women in the sample, compared with 41% of the men, said the situation was "very likely." Sixty-two percent of women 18 to 34 years of age and 71% of unmarried working women said it was very likely.

"This survey demonstrates that AIDS has instilled a high degree of fear in the population and that a great deal of education still needs to be done to change the fear into informed caution rather than hysteria," said James H. Sammons, MD, AMA executive vice-president.

Fifty percent of those questioned said they believed that everything possible needs to be done to prevent the spread of AIDS, "even if this means some people might have their rights violated." However,

42% believed that while controlling AIDS is important, "the privacy and civil rights of every citizen must be protected." Men aged 35 years and older were more likely than any other group to say that AIDS prevention efforts should be placed before privacy or civil rights considerations (59%). Forty percent of men aged 18 to 34 years agreed.

When asked what the federal government's top priority should be in its efforts to combat AIDS, 36% believed an education program should be implemented to teach people how to avoid getting the disease. Increased government funding of research was favored by 35% of those polled; 14% said widespread testing should have priority, and 9% wanted to "isolate AIDS patients from the rest of the population."

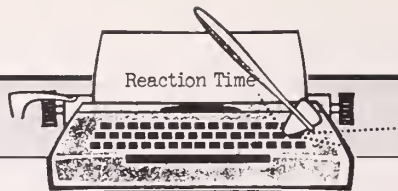
Forty-six percent of employed women, compared with 22% of married women not working outside the home, gave education top priority. Thirty-one percent of married women not employed outside the home preferred research, and 26% of them favored widespread testing, more than in any other group of respondents.

The survey was reported in the October 16 issue of *American Medical News*. 

IN MEMORIAM

1987

<i>Charles Sylvanus Maben, MD</i>	<i>February 13</i>	<i>Edgar W. Young, Jr., MD</i>	<i>April 12</i>
<i>Edward Leon Moore, MD</i>	<i>February 14</i>	<i>Paul Newman Atkins, Jr., MD</i>	<i>April 20</i>
<i>Ralph Cameron Emmott, MD</i>	<i>February 16</i>	<i>John Wesley Williams, MD</i>	<i>May 16</i>
<i>James Laurel Haddock, Jr., MD</i>	<i>February 19</i>	<i>John Jerome Coyle, MD</i>	<i>May 21</i>
<i>Donald J. Blair</i>	<i>March 16</i>	<i>J. C. Rogers, MD</i>	<i>May 22</i>
<i>Richard M. Burke, MD</i>	<i>March 18</i>	<i>Scott Allen Morris, MD</i>	<i>May 24</i>
<i>Eldon Clyde Mohler, MD</i>	<i>March 21</i>	<i>Gladys Christine Smith, MD</i>	<i>May 27</i>
<i>Paul Lewis Nave, MD</i>	<i>March 26</i>	<i>John Ronald Watson, MD</i>	<i>June 14</i>
<i>George Michael Willkom III, MD</i>	<i>March 30</i>	<i>Thomas Arthur Hosty, MD</i>	<i>June 17</i>
<i>Odis A. Cook, MD</i>	<i>April 4</i>	<i>Dan Cross Galloway, MD</i>	<i>July 12</i>
<i>Lawrence Edward Silvey, MD</i>	<i>April 9</i>	<i>Alwin Marshal Clarkson, MD</i>	<i>September 1</i>
<i>Victor Gary Anderson, MD</i>	<i>April 10</i>	<i>Rex Elmer Kenyon, MD</i>	<i>September 16</i>
		<i>Charles P. Bondurant, Jr., MD</i>	<i>October 12</i>



Crosthwait writes newspapers about Medicare premium hike

On October 6, 1987, OSMA President M. Joe Crosthwait, MD, sent the following letter to newspaper editors across the state and to the OSMA JOURNAL. The letter was published, in full or in part, by several newspapers in Oklahoma City and Tulsa.

Dear Editor: When the Department of Human Services announced last month that Medicare Part B premiums, the component of Medicare which pays for physicians' services and some other medical goods, would increase 39 percent on January 1, California Democratic Congressman Fortney "Pete" Stark drew national headlines by blaming physicians totally for this largest Medicare premium increase ever.

This vicious political rhetoric, calculated only to draw attention to an ambitious politician, is not only wrong, but a cheap shot which insults physicians and

all other health care providers who make the Medicare system work.

While I know this won't draw the headlines of Congressman Stark's misinformation, I want to set the record straight with the facts.

The 39 percent premium increase translates into a \$6.90 monthly hike, raising costs to \$24.80. A full three dollars of this increase is purely "catch-up" since Medicare Part B premiums were intentionally grossly underpriced in 1986 and 1987 when the Health Care Financing Administration chose to "spend down" the Medicare trust. Since the United States is an aging society, about one dollar of the increase will cover new Medicare beneficiaries. Another dollar results from increased utilization of medical services including newer, more sophisticated, and, therefore, more expensive drugs and technology.

Of the final \$1.50, part will help improve claims processing and about a dollar or so will go to reimburse physicians and other suppliers of medical services to Medicare patients.

If you think this increase for physician payment is unwarranted, please remember that doctors voluntarily froze their fees to Medicare patients in February, 1984, only to have Congress make this freeze mandatory five months later. When the freeze expired in January of this year, doctors generally received a one percent increase in reimbursement.

The future of Medicare is in jeopardy. It will take cooperative discussion of facts, not vituperative, self-serving political rhetoric to solve this problem and ensure the future access and quality of health care for our nation's senior citizens.

Here in Oklahoma doctors and Medicare patients are working together to ensure that future. The Tulsa County Medical Society's highly successful Very Important Patient (VIP) program, which assures Medicare assignment for qualified patients, will be implemented on a statewide basis in the months ahead.

Oklahoma's doctors will continue to speak out forcefully whenever medical care to any of our patients is compromised.

*M. Joe Crosthwait, MD
President
Oklahoma State Medical Association*

DEATHS

Charles Palmer Bondurant, Jr., MD 1929 - 1987

Neurosurgeon Charles P. Bondurant, Jr., MD, died October 12, 1987. Dr Bondurant, an Oklahoma City native, was graduated from the University of Pennsylvania School of Medicine in 1955. He served in the US Navy Medical Corps from 1958 to 1960 and returned to Oklahoma City in 1965. In addition to his private practice, Dr Bondurant was an assistant clinical professor in neurological surgery at the University of Oklahoma Health Sciences Center and a Fellow in the American College of Surgeons.

J. C. Rogers, MD 1943 - 1987

Warner physician J. C. Rogers, MD, died May 22, 1987, in a plane crash near Porter, Okla. The family practitioner, an Arkansas native, was raised in Warner and returned there to practice after his graduation from the University of Oklahoma College of Medicine in 1973.

OHA exec questions validity of state manpower report

The following letter was addressed to OSMA Executive Director David Bickham on October 14, 1987.

Dear David: As you are aware, at the September 10, 1987, meeting of the Oklahoma State Regents for Higher Education Committee on Physician Manpower, Burr Lewis, MD, presented a report entitled "Policy Options for Oklahoma Physician Training Programs to Meet Manpower Needs Beyond 2000," [OSMA JOURNAL, July 1987] which he authored along with F. Daniel Duffy, MD, and Deborah Miller, Physician Placement Officer, Tulsa Medical College.

We have serious concerns as to the validity of this study and its results for the following reasons:

1. The report was based upon 22 hospital trade areas as determined by the Oklahoma Health Systems Agency, a defunct organization whose data at best was not the most reliable data. Also, they used the annual hospital surveys which are on file at the Oklahoma Health Planning Commission which reflect patient origin as the basis to determine physician referral practices. As you well know, the origin of hospital admissions has nothing to do with physician referrals. Most physician referrals will never be admitted to a hospital. Also, many patients come to hospitals for service without a physician and must be referred by the hospital to a physician for treatment. Physicians refer to physicians and have no correlation to hospital admissions or the origin of those admissions. We believe that the study should have been based upon data from physicians on their individual referral patterns and practices.

2. The study was also based upon the very questionable GMENAC Report, which had no involvement of the Osteopathic portion of the medical community and was not accepted by the AOA or the OOA. It was also questionable as to whether it really relates to how the citizens of this state prefer to utilize medical services, rather than how the medical services providers believe they should utilize these services. The AMA has subsequently published data which doesn't support GMENAC.

3. As you are aware, most of the citizens in the rural areas prefer the services of a strong family practice physician who can treat most of the needs of all family members with referral to internists, surgeons, etc., when it becomes necessary. A report prepared by two internists may be slanted to favor

internal medicine. This report does not give preference to this desire but puts forth the medical model that certain physicians believe the public should utilize.

4. It has been stated that all of the DOs were reflected as family practice physicians rather than in their medical specialties. This should be reviewed to determine if they have been properly reflected in the report.

Unfortunately, the minutes of the committee do not reflect the negative discussion which occurred during the meeting. Hopefully, the committee at its next meeting will take action to disapprove the report.

If you have any questions concerning this matter, I'll be happy to discuss them with you.

*Bob Parks, CPA
Vice-President
Financial Affairs
Oklahoma Hospital Association*

Authors add notes on manpower, support work of commission

To the Editor: In July 1987 the *Journal of the Oklahoma State Medical Association* published an article entitled "Policy Options for Oklahoma Physician Training Programs to Meet Manpower Needs Beyond 2000." The article was written by F. Daniel Duffy, C.S. Lewis, Jr., and Deborah Miller. In June and again in September, 1987, the authors presented data before the Regents for Higher Education Advisory Committee on Physician Manpower. The data contained in these reports has been scrutinized and some conclusions need clarification. Specifically, some of the data is being used to defend a policy position to reduce funding for primary care residency positions by eliminating the Physician Manpower Training Commission. Such a use of the data is a misinterpretation and produces a dangerous, erroneous conclusion.

A map of Oklahoma produced in the paper demonstrated the percent of estimated need for physician manpower which was in place in 1986 for each of the twenty-two trade areas in the state. With the exception of Oklahoma City, all were less than 100% and only four were greater than 75%. The areas of greatest need remain in the non-urban areas of the state.

(continued)

Authors add notes (continued)

Looking specifically at the primary care category, every hospital trade area in the state, except Oklahoma City and Tulsa, has a current need for additional primary care physicians!

Oklahoma has and will continue to have relatively more physicians in osteopathic general practice and family practice with relatively fewer physicians in internal medicine and pediatrics than the average state in the United States. However, an aggregate primary care shortage exists now and that shortage will exist until the year 2000!

There is a degree of interchangeability among the types of primary care physicians. Family practitioners provide care for all ages and some care for routine pregnancies. Internists provide care for persons from adolescence to old age with greater depth in hospital care, diagnostics, and critical care. Pediatricians, by limiting their care to children, are like internists in providing a greater depth of experience with serious and complex illness. Specifically, family practice services generally stop

with primary care, and the internist and pediatrician services overlap both primary and secondary care.

All three, family practice, internal medicine, and pediatric physicians, complete a minimum of three years of training in supervised practice before entering independent practice. On the other hand, the osteopathic general practitioner arrives for independent practice having only one year of internship. The leadership of osteopathic training has indicated plans to move toward a minimum of two years training for all graduates. The Association of Medical Colleges in a publication entitled "Medical Education," published in September, 1986, states, "Graduate medical education, varying in length from three to seven years is an essential part of the preparation for physicians for independent practice, and access of US medical school graduates to residency positions is a prime concern of the Association." A minimum of three years of training in supervised internship and residency is recommended for all physicians, especially primary care physicians who practice in remote and isolated areas!

Oklahoma's areas of sparse population density



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might justify the greater proportion of family practice physicians than the nation's. We want neither underqualified nor overqualified physicians for the job, but we must have physicians with at least minimal qualifications!

The Physician Manpower Training Commission was established to fund training positions in primary care and to locate physicians in underserved areas of the state. It has been demonstrated that there is still a need for primary care physicians in many areas of Oklahoma as the state will have an eleven percent short fall of the total number of physicians in 1990.

Important gains have been made. There has been as much as a 45% increase in the availability of physicians for some regions of the state. From 1975 through 1987, the Physician Manpower Training Commission has funded in part the training of 595 MD physicians and 193 DO physicians. Of these physicians, 37% are practicing in counties other than Oklahoma and Tulsa. We feel strongly that the Physician Manpower Training Commission has made great strides in providing physicians for Oklahoma, but still has a way to go.

The majority of the projected deficit of secondary care is in psychiatry, and this is an important separate issue. The remaining short fall is in the medical and surgical subspecialties. These areas are presumed to be in ample supply in the nation. It may be unnecessary for Oklahoma planners to be more than aware of the status of these areas. The hospital-based specialties and the surgical specialties will all reach a balance between 1990 and 2000, and no new policy change need be made to impact these positions.

Responding to the perceived future excess of physicians, the University of Oklahoma has reduced its entering class by 15% based on the 1984 entering class size. The Oklahoma College of Osteopathic Medicine and Surgery should make an equal 15% reduction to bring the future total manpower for Oklahoma into balance by the year 2000.

The recommendation that the University of Oklahoma and the Oklahoma College of Osteopathic

Medicine and Surgery establish similar high standards for admission is essential in order to provide the highest qualified physicians for Oklahoma's future.

In conclusion, Oklahoma, through its Physician Manpower Training Commission, has improved its primary care physician shortage and has created a dispersion of physicians into underserved areas of the state. That job is not complete! Dismantling the Physician Manpower Training Commission would produce a backslide which might never be reversed. The issue is not the percentage of family practice, general practice, medicine, or pediatric physicians needed for Oklahoma's primary care, but rather that all primary care physicians be well trained.

The Physician Manpower Training Commission should continue its good work with full financial support.

*F. Daniel Duffy, MD
C. S. Lewis, Jr., MD
Tulsa*

WORTH REPEATING

Generics for your patient . . . A good deal, or a good deal less?

The following commentary appeared in the October 9, 1987, issue of American Medical News under the headline "Substitution doesn't always serve the patient." Copyright 1987, American Medical News. Reprinted by permission.

American physicians are increasingly believing their patients have been betrayed by the pharmacy profession of the United States. In an era of therapeutic brilliance, patient care is now being damaged by a persistent campaign of generic substitution. The substitution of inferior drugs has been promoted from a minor irritant issue to a daily and important problem by a coincident expiration of a flock of patents in important drugs.

Encouraged by cost consciousness in the health care field, the pharmacists of the nation — abetted by the Food and Drug Administration (FDA) — have foisted on their patients a dangerous mass of inferior generic drug substitutions. By claiming chemical equivalence, the absquatulating drug companies

(continued)

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Generics for your patient (continued)

have made and placed in the nation's pharmacies a huge batch of drugs that no scientist is able to warrant as therapeutically equal to the brand-name precursor.

Covered legally by various state substitution laws, and coerced by insurance and governmental agency financial incentives, many pharmacists have ignored doubts and fears advanced by practicing physicians and gone full steam ahead in a large scale substitution campaign based on money instead of science.

The November *FDA Drug Bulletin* tried to reassure that generics are really all right because of FDA requirements. However, the listed criteria do not require therapeutic equivalence except by a most tortured and unscientific definition of the term. The FDA itself inserts a major caveat: "FDA recommends generic substitution only among products it has

evaluated as being therapeutically equivalent" (*FDA Drug Bulletin*/November, 1986, p 15).

The trouble is, few outside the FDA seem to have this list of "therapeutically equivalent" drugs, known as the *Orange Book* to the FDA. Few in the medical or pharmacy professions have a copy, and apparently no one heeds it while substituting promiscuously.

The US Government Printing Office in Washington recently advised our hospital pharmacy that the sixth edition of the *Orange Book* was out of print and unavailable. The seventh edition is not in printing yet, and they couldn't state when it would be available.

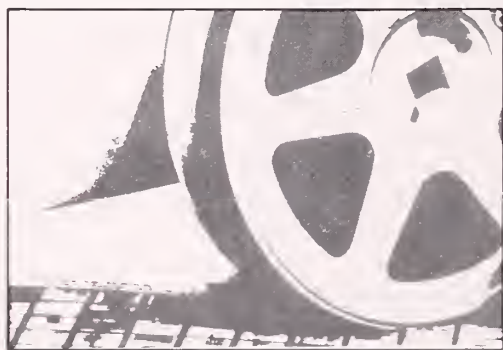
We are forced to the sad conclusion that in the United States today hundreds of generic substitutions are being made daily when the substituting pharmacist hasn't the foggiest idea whether the substituted drug is equal to or pathologically inferior to the prescribed preparation. Further, there is cause to believe that government agencies, insurance companies, and drug companies reap more of the monetary benefit of generic substitution than does the patient (*Journal of the American Medical Association*, Vol 256 #18, p 2523). Many conscientious pharmacists are profoundly troubled by the dilemma facing them today.

In daily practice, all too often the physician finds out about the inferior substitute when the patient deteriorates and the therapeutic blood level is found to be low by the laboratory. A patient compliance history then frequently reveals the generic substitution. An increasing incidence of these clinical fiascos has led to a major loss of confidence in the pharmacy profession and the FDA.

It is apparent that the FDA should undertake a fundamental upgrading of the requirements for marketing generic drugs. A consultation with the medical scientific community could produce regulations that the practicing physician could come to trust. The pharmacy profession needs to rededicate itself to the ideal of providing the patient with the grade of medicine the physician has prescribed. The government agencies and the insurance companies should be legally prohibited from using financial incentives to compromise quality in medications. Every pharmacist in every pharmacy in the nation should have at hand and use the reference book that permits him to know that the generic substitute he uses is therapeutically equivalent.

—Ray V. McIntyre, MD
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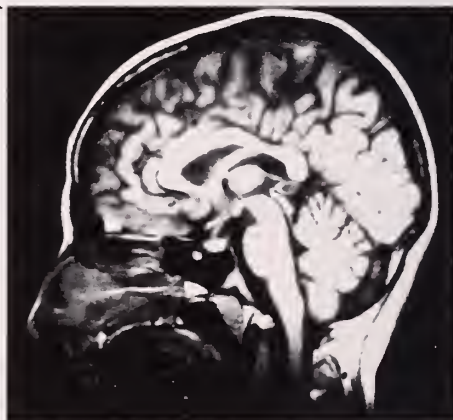
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Key to Abbreviations

- (B) Book review (Book Shop)
- (C) Commentary
- (E) Editorial
- (H) Okla State Dept of Health
- (L) Letter (Reaction Time)
- (P) Picture
- (S) Scientific
- (Sp) Special
- (W) Worth Repeating

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REYE SYNDROME

Reye syndrome is a ***rare but dangerous*** condition that can develop from ***flu or chicken pox***. It occurs mainly in ***children under 16***, usually when they ***appear to be recovering***. Watch for these signs:

- ***Persistent vomiting***
- ***Fatigue***
- ***Confusion and belligerence.***

If your child displays any of these symptoms, ***consult a doctor immediately.***

Some studies indicate that there may be an association between the use of ***aspirin*** for flu and chicken pox and the development of Reye syndrome. Further studies are being conducted on this possibility. In the meantime, the ***U.S.***

Surgeon General suggests that you check with your doctor before using aspirin or any medication when your child has flu or chicken pox.

—A message from the Food and Drug Administration.

*** WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

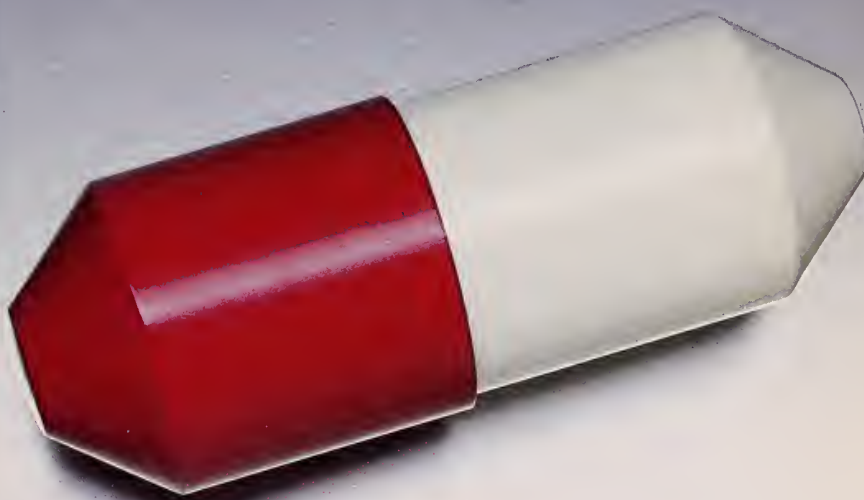
Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ.L42

In Hypertension*... When You Need to Conserve K⁺

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Serum K⁺ and BUN should be checked periodically (see Warnings and Precautions).



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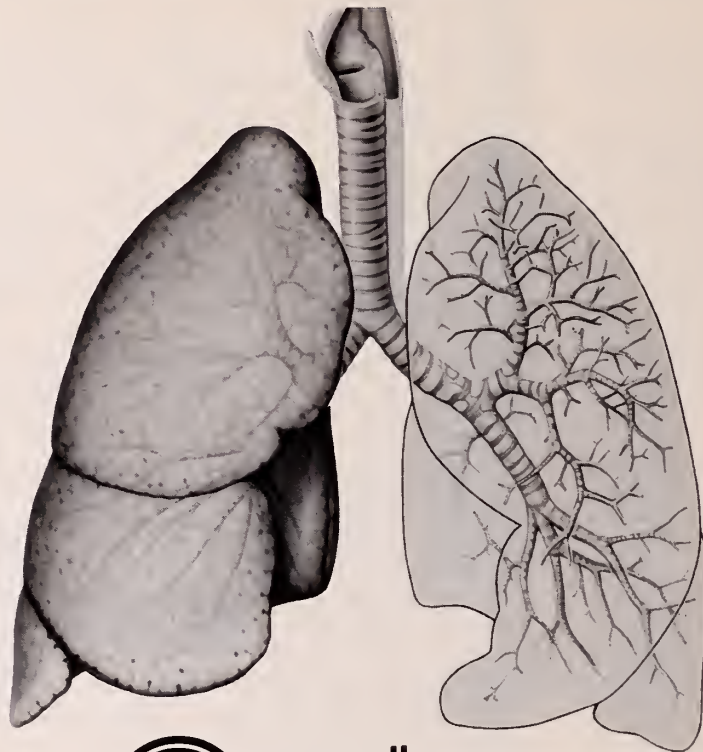
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Consider the causative organisms...



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250-mg Pulvules[®] t.i.d.
offers effectiveness against
the major causes of bacterial bronchitis

Haemophilus influenzae and *Streptococcus pneumoniae*
(ampicillin-susceptible and ampicillin-resistant)

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor[®] (cefactor)

Summary. Consult the package literature for prescribing information.

Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication:
Known allergy to cephalosporins.

Warnings:

CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients. Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthritis and, frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nerv-

ousness, insomnia, confusion, hypertension, dizziness, and somnolence have been reported.

- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology


- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinistest[®] tablets but not with Tes-Tape[®] (glucose enzymatic test strip, Lilly).

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.
Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

A woman with dark hair, wearing an orange long-sleeved shirt and dark pants, sits alone at a small white round table in a cafe. She is looking down with a somber expression. The cafe has many similar white tables and heart-shaped metal chairs, all of which are empty except for her. The background is a dark, textured wall.

**"Living in the city
is lonely enough...
with herpes it's like
solitary confinement."**

ZOVIRAX[®]
(acyclovir)
CAPSULES

**Prevent genital herpes
recurrences
month after month with
daily therapy.**

*(In controlled studies, recurrences were
totally prevented for 4 to 6 months in up to
75% of patients.)*

*Please see last page of this advertisement for
brief summary of prescribing information.*

ZOVIRAX[®] (acyclovir) CAPSULES

**Help free your
patients from
recurrences.**

Daily therapy

Coping with genital herpes is rarely easy. For some, the worst part is the pain and discomfort of frequent attacks — month after month, year after year. For others, the emotional burden presents a more difficult problem, leading to social isolation, anxiety, and diminished self-esteem.

Prevent or reduce recurrences

Although your patients have to live with herpes, they shouldn't have to suffer. Daily therapy with ZOVIRAX CAPSULES can help free them from the cycle of recurrent genital herpes. For many, one capsule three times a day can suppress recurrences completely while on therapy.

Generally well tolerated

Daily therapy with ZOVIRAX CAPSULES is generally well tolerated. The most frequent adverse reactions reported during clinical trials were headache, diarrhea, nausea/vomiting, vertigo, and arthralgia.

The physical and emotional difficulties posed by genital herpes are unique for each patient. The frequency and severity of recurrent episodes, as well as the emotional impact of the disease, should be considered when selecting daily therapy with ZOVIRAX CAPSULES.

*Please see brief summary of
prescribing information on next page.*



Prevent recurrences month after month*

ZOVIRAX®

(acyclovir) CAPSULES

Brief Summary

INDICATIONS AND USAGE: Zovirax Capsules are indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes in certain patients.

The severity of disease is variable depending upon the immune status of the patient, the frequency and duration of episodes, and the degree of cutaneous or systemic involvement. These factors should determine patient management, which may include symptomatic support and counseling only, or the institution of specific therapy. The physical, emotional and psycho-social difficulties posed by herpes infections as well as the degree of debilitation, particularly in immunocompromised patients, are unique for each patient, and the physician should determine therapeutic alternatives based on his or her understanding of the individual patient's needs. Thus Zovirax Capsules are not appropriate in treating all genital herpes infections. The following guidelines may be useful in weighing the benefit/risk considerations in specific disease categories:

First Episodes (primary and nonprimary infections — commonly known as initial genital herpes):

Double-blind, placebo-controlled studies have demonstrated that orally administered Zovirax significantly reduced the duration of acute infection (detection of virus in lesions by tissue culture) and lesion healing. The duration of pain and new lesion formation was decreased in some patient groups. The promptness of initiation of therapy and/or the patient's prior exposure to Herpes simplex virus may influence the degree of benefit from therapy. Patients with mild disease may derive less benefit than those with more severe episodes. In patients with extremely severe episodes, in which prostration, central nervous system involvement, urinary retention or inability to take oral medication require hospitalization and more aggressive management, therapy may be best initiated with intravenous Zovirax.

Recurrent Episodes:

Double-blind, placebo-controlled studies in patients with frequent recurrences (6 or more episodes per year) have shown that Zovirax Capsules given for 4 to 6 months prevented or reduced the frequency and/or severity of recurrences in greater than 95% of patients. Clinical recurrences were prevented in 40 to 75% of patients. Some patients experienced increased severity of the first episode following cessation of therapy; the severity of subsequent episodes and the effect on the natural history of the disease are still under study.

The safety and efficacy of orally administered acyclovir in the suppression of frequent episodes of genital herpes have been established only for up to 6 months. Chronic suppressive therapy is most appropriate when, in the judgement of the physician, the benefits of such a regimen outweigh known or potential adverse effects. In general, Zovirax Capsules should not be used for the suppression of recurrent disease in mildly affected patients. Unanswered questions concerning the human relevance of *in vitro* mutagenicity studies and reproductive toxicity studies in animals given very high doses of acyclovir for short periods (see Carcinogenesis, Mutagenesis, Impairment of Fertility) should be borne in mind when designing long-term management for individual patients. Discussion of these issues with patients will provide them the opportunity to weigh the potential for toxicity against the severity of their disease. Thus, this regimen should be considered only for appropriate patients and only for six months until the results of ongoing studies allow a more precise evaluation of the benefit/risk assessment of prolonged therapy.

Limited studies have shown that there are certain patients for whom intermittent short-term treatment of recurrent episodes is effective. This approach may be more appropriate than a suppressive regimen in patients with infrequent recurrences.

Immunocompromised patients with recurrent herpes infections can be treated with either intermittent or chronic suppressive therapy. Clinically significant resistance, although rare, is more likely to be seen with prolonged or repeated therapy in severely immunocompromised patients with active lesions.

CONTRAINDICATIONS: Zovirax Capsules are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulation.

WARNINGS: Zovirax Capsules are intended for oral ingestion only.

PRECAUTIONS: General: Zovirax has caused decreased spermatogenesis at high doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS—Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage and length of treatment should not be exceeded (see DOSAGE AND ADMINISTRATION).

Exposure of Herpes simplex isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of Herpes simplex virus to acyclovir and clinical response to therapy has yet to be established.

Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy.

Drug Interactions: Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of 50, 150 and 450 mg/kg given by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. In 2 *in vitro* cell transformation assays, used to provide preliminary assessment of potential oncogenicity in advance of these more definitive life-time bioassays in rodents, conflicting results were obtained. Acyclovir was positive at the highest dose used in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative in another transformation system considered less sensitive.

In acute studies, there was an increase, not statistically significant, in the incidence of chromosomal damage at maximum tolerated parenteral doses of 100 mg/kg acyclovir in rats but not Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters. In addition, no activity was found after 5 days dosing in a dominant lethal study in mice. In 6 of 11 microbial and mammalian cell assays, no evidence of mutagenicity was observed. At 3 loci in a Chinese hamster ovary cell line, the results were inconclusive. In 2 mammalian cell assays (human lymphocytes and L5178Y mouse lymphoma cells *in vitro*), positive responses for mutagenicity and chromosomal damage occurred, but only at concentrations at least 400 times the acyclovir plasma levels achieved in man.

Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg day, p.o.) or in rats (25 mg/kg day, s.c.). At 50 mg/kg day s.c. in the rat, there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg day. No effect upon implantation efficiency was observed when the same dose was administered intravenously. In a rat peri- and postnatal study at 50 mg/kg day s.c., there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the F₁ generation. Although not statistically significant, there was also a dose related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg day and 25 mg/kg day, s.c. The intravenous administration of 100 mg/kg day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size. However, at a

maximum tolerated intravenous dose of 50 mg/kg day in rabbits, there were no drug-related reproductive effects.

Intraperitoneal doses of 320 or 80 mg/kg day acyclovir given to rats for 1 and 6 months, respectively, caused testicular atrophy. Testicular atrophy was persistent through the 4-week postdose recovery phase after 320 mg/kg day; some evidence of recovery of sperm production was evident 30 days post-dose. Intravenous doses of 100 and 200 mg/kg day acyclovir given to dogs for 31 days caused aspermatogenesis. Testicles were normal in dogs given 50 mg/kg day, i.v. for one month.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg day, p.o.), rat (50 mg/kg day, s.c.) or rabbit (50 mg/kg day, s.c. and i.v.). There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in animal studies, the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Zovirax is administered to a nursing woman. In nursing mothers, consideration should be given to not using acyclovir treatment or discontinuing breastfeeding.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS—Short-Term Administration: The most frequent adverse reactions reported during clinical trials were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat.

Long-Term Administration: The most frequent adverse reactions reported in studies of daily therapy for 3 to 6 months were headache in 33 of 251 patients (13.1%), diarrhea in 22 of 251 (8.8%), nausea and/or vomiting in 20 of 251 (8.0%), vertigo in 9 of 251 (3.6%), and arthralgia in 9 of 251 (3.6%). Less frequent adverse reactions, each of which occurred in less than 3% of the 251 patients (see number of patients in parentheses), included skin rash (7), insomnia (4), fatigue (7), fever (4), palpitations (1), sore throat (2), superficial thrombophlebitis (1), muscle cramps (2), paronychia (1), menstrual abnormality (4), acne (3), lymphadenopathy (2), irritability (1), accelerated hair loss (1), and depression (1).

DOSAGE AND ADMINISTRATION: Treatment of initial genital herpes: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 10 days (total 50 capsules).

Chronic suppressive therapy for recurrent disease: One 200 mg capsule 3 times daily for up to 6 months. Some patients may require more drug, up to one 200 mg capsule 5 times daily for up to 6 months.

Intermittent Therapy: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 5 days (total 25 capsules). Therapy should be initiated at the earliest sign or symptom (prodrome) of recurrence.

Patients With Acute or Chronic Renal Impairment: One 200 mg capsule every 12 hours is recommended for patients with creatinine clearance ≤ 10 mL/min/1.73 m².

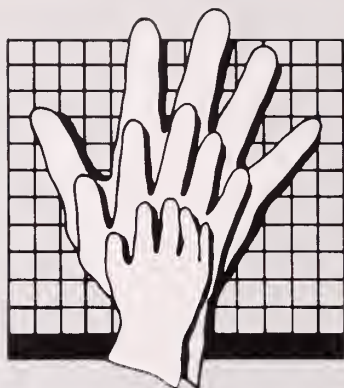
HOW SUPPLIED: Zovirax Capsules (blue, opaque) containing 200 mg acyclovir and printed with "Wellcome ZOVIRAX 200" - Bottles of 100 (NDC-0081-0991-55) and unit dose pack of 100 (NDC-0081-0991-56).

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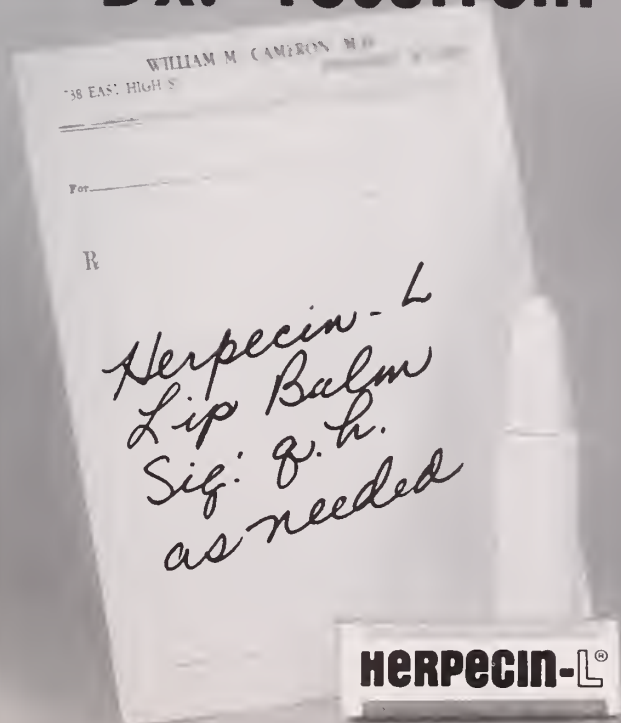
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All manuscripts should adhere to the style adopted by the American Medical Association as illustrated in *JAMA* and detailed in the AMA's *Manual for Authors & Editors*. Footnotes, bibliographies, and legends for illustrations should be typewritten, double-spaced, on separate sheets. References are to be listed in the order of their appearance in the article.

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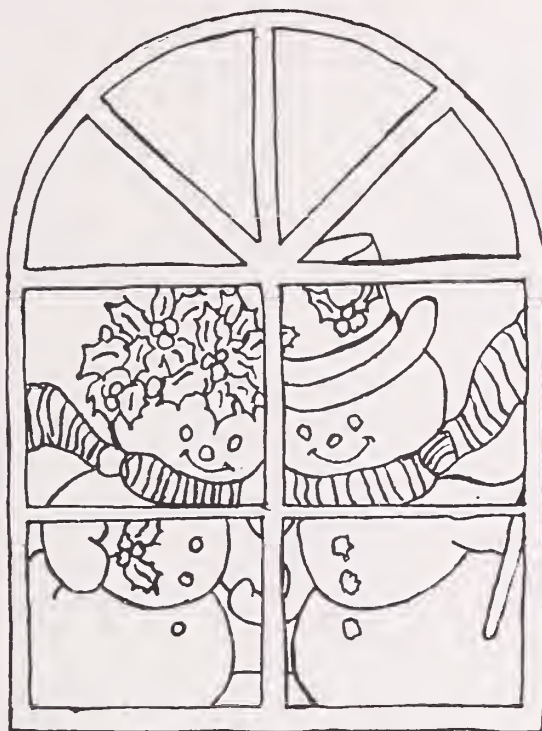
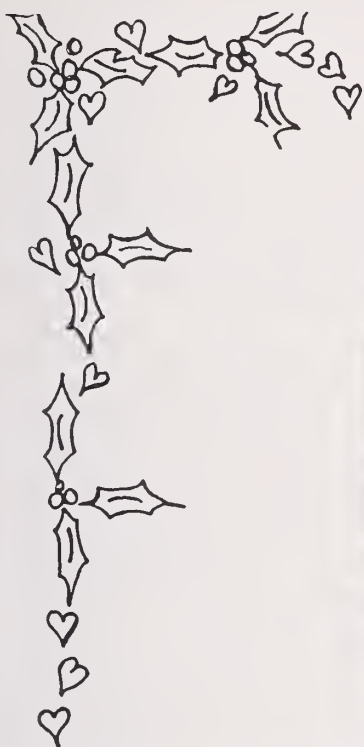
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Authors will receive reprint order forms from the Transcript Press, 222 East Eufaula, Norman, Oklahoma 73069, prior to publication of their articles. Other requests for reprints must be made to the Transcript Press within 30 days after publication.

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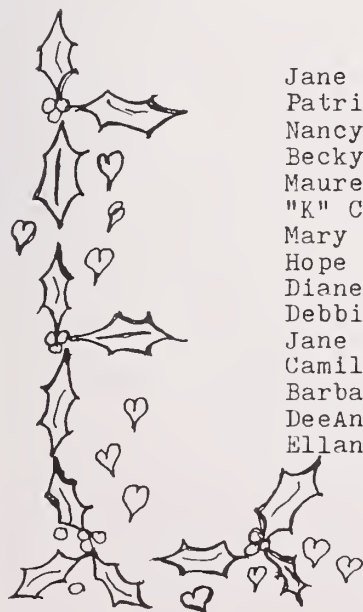


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THE LAST WORD

■ **OSMA has welcomed two new staff members** in recent weeks. Claudia Kamas is the new coordinator of special projects and will act as liaison to the State Department of Health, the OU Health Sciences Center, and other health-related groups. Currently she is working to identify and coordinate the activities of all groups involved in AIDS activities in Oklahoma. Sandy Ruble is secretary to Assistant Executive Director Robert Baker and Associate Director Otie Ann Carr. She comes to OSMA from the state capitol, where for three years she was secretary to Representative Bill K. Brewster.

■ **Lyle Kelsey, former deputy executive director** of OSMA, has been named executive director of Oklahomans Against Lawsuit Abuse (OALA), a tort reform coalition. He succeeds the late Donald J. Blair. Kelsey left OSMA in 1984, ending seven years of service to become president of Allied Nursing, Inc.

■ **Mark your calendars now. The 1988 OSMA Annual Meeting** will be May 5-8 at Shangri-La Resort, Afton, Oklahoma.

■ **Postcards have become another tool in the** fight against tobacco use in the United States. Physicians are being asked to notify their congressional representatives of every patient death related to tobacco use. Preprinted postcards, available on request from the OSMA, are being distributed for this purpose. The cards note that one of the representative's constituents, a tobacco user, has died of a tobacco-related disease. Causes of death are listed, with boxes provided for marking the appropriate cause. A closing paragraph urges support for legislation prohibiting tobacco advertising and promotion. To order cards, telephone the OSMA, 1-800-522-9452 or (405) 848-9571.

■ **The AIDS drug zidovudine (previously, AZT)** has a number of side effects, including hematologic problems, rashes, nausea, insomnia, muscle pains, and headache. A letter in the October 16 *Journal of the American Medical Association* says liver toxicity may be another side effect. Andra J. Melamed, PharmD, of Memorial Sloan-Kettering Cancer Center, New York City, and colleagues say three of 28 HIV-positive patients they treated with zidovudine since October 1986 developed transient liver function test abnormalities that might have been attributed to the drug. Therapy was interrupted

or stopped in each case and test values returned to baseline. "In the (drug) labeling provided by the manufacturer, hepatotoxicity and abnormal liver function test results are not listed as adverse effects," the letter says. "Physicians should be aware that hepatitis may complicate zidovudine treatment and may necessitate interruption or even cessation of . . . therapy."

■ **Robert Allen Breedlove, MD, a Stillwater** dermatologist, was recently featured on the cover of *Referee*, a magazine devoted to sports officiating. Dr Breedlove has been officiating high school and college football and high school basketball for 20 years, as well as writing frequent articles on the subject. The *Referee* cover photo shows him standing beside his car with the license plate DR REF clearly visible. For his second car, Dr Breedlove has ordered a plate reading STRIPE. A real fanatic about his avocation, he confesses his dream is to officiate an NBA title game in Boston Garden between the Celtics and the Lakers.

■ **The OSMA is distributing attractive red,** white, and blue patient brochures explaining the new Very Important Patient (VIP) program. Office signs identifying physicians as participants in the program are also available. The program was developed to assist low-income Medicare recipients in identifying physicians who will accept Medicare assignment. For information about the program or to order brochures, contact your county medical society or call OSMA headquarters, 1-800-522-9452 or (405) 843-9571.

■ **Cardiac lesions, while clinically silent,** are common findings in AIDS patients, says a report in October's *Archives of Pathology and Laboratory Medicine*. The study, by Eneida O. Roldan, MD, of the University of Miami School of Medicine, Miami, Fla, and colleagues, reviewed autopsy data on 54 AIDS patients; pathologic changes were seen in 30. Myocarditis, inflammation of the muscular walls of the heart, was the most common finding, affecting 83% of the patients. In six patients, the myocarditis was caused by toxoplasmosis, a parasitic infection. No cause could be found in the remaining patients, the study says, concluding that "cardiac disease is common (in AIDS patients), may be clinically significant, and that an autopsy is crucial for the documentation and diagnosis of these diseases, as well as for the diagnosis of AIDS itself." □

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Prevention of hypokalemia requires particular attention in patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis and ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, certain diarrheal states, or other states where hypokalemia is thought to represent particular added risk to the patients.

In patients with hepatic cirrhosis and ascites, sudden alterations of electrolyte balance may precipitate hepatic encephalopathy and coma. Treatment in such patients is best initiated in the hospital with small doses and careful monitoring of the patient's clinical status and electrolyte balance. Supplemental potassium and/or spironolactone may prevent hypokalemia and metabolic alkalosis in these patients. In rats, dogs and guinea pigs, Bumex has been shown to produce ototoxicity. Since Bumex is about 40 to 60 times as potent as furosemide, it is anticipated that blood levels necessary to produce ototoxicity will rarely be achieved. The potential for ototoxicity increases with intravenous therapy, especially at high doses.

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Especially in presence of impaired renal function, use of parenterally administered Bumex should be avoided in patients to whom aminoglycoside antibiotics are also being given, except in life-threatening conditions.

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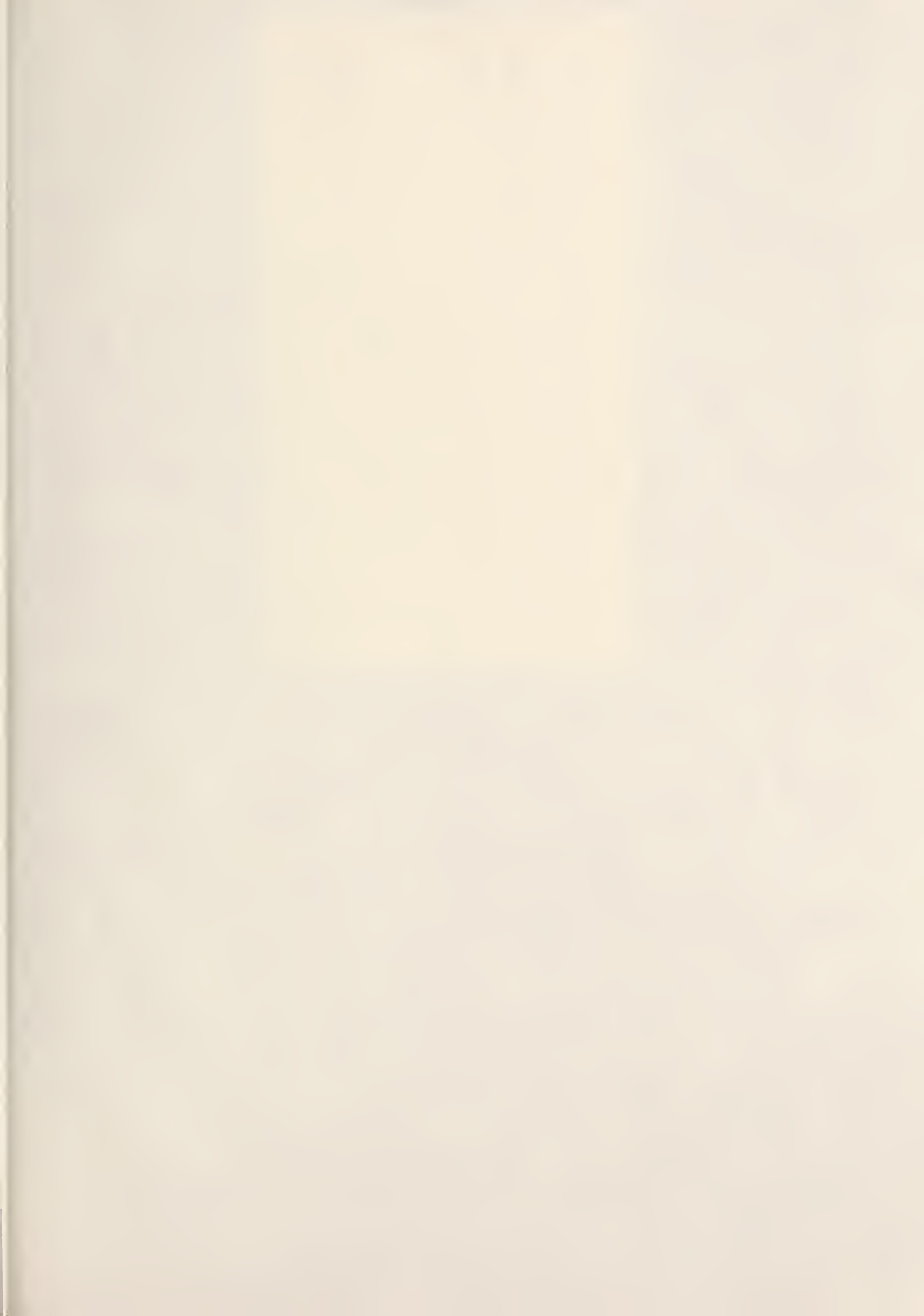
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